

Automobile Injury Appeal Commission

Province of Saskatchewan

Citation: *N.A. v. Saskatchewan Government Insurance,*
2004 SKAIA 012
Date: 20040315
File: 028 of 2003

BETWEEN

N.A., Applicant

and

Saskatchewan Government Insurance, Respondent

Appearances:
N.A., Applicant
Jocelyn Clement, for the Respondent

Before: **Ann Phillips, Q.C., Chair**
Beverly Cleveland, Commission Member
Mukesh Mirchandani, Commission Member

THIS DECISION HAS BEEN EDITED TO PROTECT THE PERSONAL AND HEALTH INFORMATION OF INDIVIDUALS BY REMOVING PERSONAL IDENTIFIERS AND OTHER IDENTIFYING INFORMATION.

Heard at Regina, Saskatchewan
November 28, 2003
and at Yorkton, Saskatchewan
December 3, 2003

DECISION

[1] The Appellant, N.A., appeals from a decision of Saskatchewan Government Insurance (“SGI”) dated February 12, 2003 that:

- (1) terminated funding for psychological counselling effective February 19, 2003;
- (2) terminated funding for medication directly related to depression effective February 19, 2003;

[2] She also appeals a decision of SGI dated January 9, 2003 upholding a previous decision dated July 11, 2002. These decisions:

- (1) terminated funding for passive therapy: physiotherapy, massage therapy, chiropractic and pain shots;¹
- (2) denied reimbursement of travel expenses to Regina for referrals made by her [location] general practitioner until documentation was received from him relating the appointments to her motor vehicle accident;
- (3) mentioned but did not decide on funding for glucosamine sulphate, which SGI was to cover until July 2002, “at which time it would be reviewed”.

FACTS

[3] The Appellant was injured in a motor vehicle accident on September 13, 1998, when her car was rear ended. While she had a previous history of nine motor vehicle accidents beginning in 1976, which caused neck and back problems, and while she also had a history of major depressive illness for a number of years² before the 1998 accident, she was at the time coping well, was employed as an office cleaner and self-employed as a babysitter, and had been hired for a position as a parental care worker in a residential facility in which she would do kitchen

¹ Both decisions.

² Since at least 1985.

work, breadmaking, baking and other domestic chores, a job she had done before. She had had some supportive counselling, and her depression was under control with 50 mgs. of Trazadone per day.

[4] The initial diagnosis was Whiplash Associated Disorder I of the cervical spine, Low Back Pain II, lateral epicondylitis.

[5] When she began primary care physiotherapy on September 28, the initial diagnosis was generally confirmed as cervical WAD II, mechanical back pain grade II, right shoulder girdle dysfunction and left forearm myofascial dysfunction.

[6] She continued with physiotherapy but was referred for a secondary assessment at Canadian Back Institute (“CBI”) January 27, 1999, where she was diagnosed as follows:

Accident Related Injuries:

1. Left elbow myofascial pain possibly lateral epicondylitis;
2. Right shoulder sprain/strain injury;
3. Re-aggravation of chronic episodic mechanical neck and lower back pain;
4. Post traumatic headaches.

Non-Accident Related:

1. Major depression;
2. Decompensation of an underlying psychiatric illness, depression, secondary to the MVA in September, 1998.

[7] In view of the diagnosed major depression, and the relatively small improvement during the course of physiotherapy, CBI strongly recommended that she attend a tertiary level program, i.e. the FIT for Active Living program at Saskatoon City Hospital as soon as possible, where she would obtain support in pain management.

[8] The Appellant did not agree with the CBI report, stating:

“It was never brought up to me at this assessment that the recommendation would be for me to attend the FIT program and I was never asked or consulted in any way as to how I would feel about attending there. This decision was made by four people that never saw me before that day, and never contacted my family doctor knowing there was pre-existing depression.”

[9] She did attend the FIT assessment on March 8 and 9, 1999. The FIT team which included a physical therapist, an occupational therapist, a chiropractor, a specialist in physical medicine and rehabilitation and a psychologist, as well as a rehabilitation coordinator, recommended tertiary level care for 12 weeks of half day programming, to dovetail with her husband's requirements. The Appellant's husband had also been injured in the accident, and had a cardiac condition.

[10] The assessment diagnosed the following:

"MVA related:

1. Aggravation of chronic pain syndrome
2. Aggravation of pre-existent depression
3. Aggravation of sleep disorder

Non-MVA related:

1. Smoking
2. Osteoarthritis of knees
3. Query carpal tunnel syndrome³
4. Borderline elevated blood pressure"

[11] At this point, matters reached an impasse. The Appellant did not want to attend the FIT tertiary program of treatment. She felt that she had deteriorated from the level she had reached in physiotherapy before the secondary assessment. She did not like being told by SGI that she had to attend or her benefits would be cut off.⁴ She disliked being told she was part of a team and told that the tertiary program would be best for her, without paying attention to her concerns. She disliked being asked to sign a contract to be in the program. She objected that her anti-depressant medication had to be doubled twice and that the FIT program was a situation that she could not handle. She was mistrustful of everyone in the FIT program.

[12] On the other side of the impasse, SGI and its consultants all stressed the need for the Appellant to attend a tertiary level program for physical and psychological treatment. There are only two tertiary level programs accepted by SGI in the province: at FIT in Saskatoon and at

³ It was subsequently agreed that the carpal tunnel syndrome had not preceded the accident and was in fact MVA related.

⁴ Under section 185(e) and (g) of *The Automobile Accident Insurance Act* then in force, SGI may terminate a benefit if a person, without valid reason, is not available for treatment recommended by a practitioner and

Wascana Rehabilitation Centre in Regina. The latter was not an option for the Appellant due to her husband's medical condition, and her own unwillingness.

[13] In the meantime, she had been referred to an orthopaedic surgeon for continued problems with her right arm and shoulder. Dr. Taillon suggested a corticosteroid injection to sort out what pain came from her shoulder and what from her neck. He organized an arthrogram to consider the possibility of a rotator cuff tear.

[14] The Appellant thought the pain would add to her difficulties in the FIT program. However, on April 28, 1999, she began the FIT program and signed the contract with FIT on the (reasonable) assumption that if she did not sign SGI would terminate her benefits. SGI confirmed this by letter April 30. She complained to her MLA, who followed up at a senior level with SGI. FIT then refused to take her into the program until these issues were under control. FIT's psychologist had advised that she was not mentally capable of pursuing active rehabilitation at this time, as it would cause too much stress and fatigue. FIT recommended referring her to a psychologist, Dr. Chartier, and continuing with the physiotherapy program at Daniels Kimber.

[15] After months of discussions with various caregivers (Chartier, McGettigan, Kimber and FIT) and a consultation with SGI's psychologist consultant, Dr. Glenn Pancyr, SGI proposed that she attend an augmented level of secondary care at Daniels Kimber Physiotherapy Clinic while continuing to see Dr. Chartier. This twelve week program began May 4, 2000. An additional twelve weeks was recommended. During the second twelve weeks, there was a flare-up with her right shoulder, identified by Dr. Taillon as a Type II acromion with a recommendation for arthroscopy. When carried out, the arthroscopy showed a partial supraspinatus articular surface tear and fraying of the biceps tendon. These were debrided and bursal adhesions were removed.

[16] Following the surgery she returned to Daniels Kimber for primary care physiotherapy for her shoulder.

the insurer, or, without valid reason, does not follow or participate in a rehabilitation program made available by the insurer.

[17] She was referred for a Functional Capacity Evaluation (FCE) in July, 2001. The FCE found:

- “1. WAD II, LBP II, right shoulder dysfunction, primarily myofascial, incoordination of muscles resulting in secondary pain.
2. The client has a high level of perceived disability, this perceived disability is in keeping with how she presented herself in the evaluation.
3. The client’s perceptions may not match objective information.
4. The client performed marginally in testing. Objective measures may not reflect the client’s maximal effort.
5. The client presents with a moderate to severe disability for work, considering both physical and psychosocial presentation.
6. The client presents with a mild to moderate disability for house and yard, considering both physical and psychosocial presentation.
7. The client presents with a moderate to severe disability for pre-injury recreation, considering both physical and psychosocial presentation.”

[18] Her biomechanical situation had been optimized, but functional conditioning had not. Nevertheless, it was recommended that tolerances could be better improved on the job than in a rehabilitation setting. While she was capable of working only at the sedentary level, she identified a potential job in a family greenhouse as an option. While no job description or requirements were provided, it was thought that because it was a family business adequate accommodation (limited lifting and carrying, the ability to use a sit-stand chair, limitation to work requiring only occasional reaching) might be available.

[19] The Appellant took the job at the greenhouse in [location], beginning in January, 2002. It was to be a graduated return to work. Arrangements were made for her to be seen by a Regina physiotherapist, Scott Anderson, with occupational therapy services provided by Innovative Rehabilitation Consultants (IRC) of Saskatoon.

[20] There were problems with the graduated return to work program, as the Appellant was having continued “winging” in her right shoulder with neck pain, spasms and disrupted sleep. She was monitored at work by the occupational therapist, who provided equipment, urged regular breaks and good body mechanics. The initial assessment by the physiotherapist expressed concern at her very poor shoulder function and chronic mechanical back pain, in view of the non-sedentary nature of the job, which would require a significant amount of reaching. He also referred to her level of perceived disability.

[21] Because of the pain she was experiencing, the Appellant sought a new family physician in [location], who arranged for ultrasound of her right shoulder. SGI became concerned that the new family physician was not aware of her previous medical history, and was beginning to order tests and make referrals for a condition that SGI thought had already been investigated extensively. By mid-March, she had still not got past one and one-half hours per day in her graduated return to work. She began taking massage therapy treatment twice a month, for which she paid herself from late March through July.

[22] In June, she was seen by Dr. Jones, an orthopaedic surgeon, who diagnosed ongoing tendonitis in her shoulder, but an intact rotator cuff. He suggested that an MRI be done to rule out any other soft tissue problems and a bone scan to rule out reflex sympathetic dystrophy. He stated that his overall feeling was that he was not going to be able to help her very much.

[23] Late in June, Anderson reported on his physiotherapy treatments. He noted that she had had no regression in function, although she had had two flare-ups which had settled. He concluded that she needed to find exercises and stretches for symptom management, and have to pace her activities. "Further passive treatment does not appear indicated, as it is not leading to any progression in her recovery." He observed that her job at the greenhouse exceeded her functional capabilities, and said that the major focus must be on finding an alternate occupation.

[24] As a result of Anderson's report, and because of the lack of information from the family physician, SGI's adjuster wrote the Appellant on July 11, 2002 stating:

"It is advised that ongoing passive therapy is not leading to any progression in your recovery, therefore, SGI will be unable to provide funding for passive therapy, such as physiotherapy, massage therapy, chiropractic and pain shots at this time."

[25] The door was left open in the event the family physician provided additional medical information.

[26] On August 20, an IRC representative, Garry Derenoski, met with the Appellant's family physician. He summarized the conversation in a letter to him dated August 20, 2002. Over the 11 visits between February 8 and July 22, Dr. DeWitt had treated her as a "person in pain" in the

manner in which he treated all patients. He did not have any past medical history other than that provided by his patient. He was not aware of the return to work plan. When she had asked for massage therapy, he had recommended physiotherapy but was aware that she had also taken massage therapy. He had requested the medical information that IRC had on its file, with summaries. IRC requested his chart notes. IRC faxed a copy of this letter to SGI, with a request for instructions on providing the complete file including vocational reports, and whether or not to prepare a summary, which Derenoski estimated would take four to five hours. A “summary” of the chart notes was provided by the doctor on September 10.

[27] In all of this, we see no misrepresentations by SGI or IRC. The Appellant states that on September 10, 2002, “they could not pay me as they still had not received anything from Dr. DeWitt. I informed her that I had called his office and was told the information was sent”, However, the documentation shows that SGI did not receive anything before September 10 other than the IRC letter outlining the discussion with the doctor and Dr. DeWitt’s note of August 23 referring to the meeting and saying he would send a letter after receiving the new information.

[28] An SGI internal hearing was held on December 18 to review the decision to deny passive treatment. The review decision is dated January 9, 2003.

Miscellaneous Issues: “Determination”, Glucosamine, Travel Expenses

[29] One issue raised but disposed of at the hearing was a “determination” of employment was made for the Appellant as a receptionist. No review of the decision was requested within the 60 days of the date of the decision, April 25, 2002, prescribed by section 194(1) of *The Automobile Accident Insurance Act*, and SGI declined to deal with it. The issue was not raised on this appeal.

[30] The Appellant requested payment for glucosamine sulphate and reimbursement for travel expenses to Regina for medical appointments in Regina. The glucosamine sulphate was to be covered until July 2002, at which point there would be a review. In argument, Ms Clement noted that payment had not in fact been terminated, but the Appellant was no longer taking it. In any event, it was not a prescription drug. [The documents] deal with this: Dr. DeWitt did not

prescribe it, and in fact, the Appellant had never mentioned her usage of this medication to him. We are satisfied that these expenses cannot be reimbursed.

[31] The claim for travel expenses was reviewed: payment for some travel expenses was allowed, others deferred until an original legible receipt could be provided. This appears to be reasonable.

[32] The Appellant also submitted a claim for five tablets of Apo-Lorazepam (\$7.51) SGI asked that Dr. DeWitt provide information on the need for prescription drug Apo-Lorazepam in relation to the MVA.

[33] SGI was asked to submit evidence on this point after the hearing, and did so. On the Apo-Lorazepam prescription, Dr. DeWitt had prescribed this for complaints of fatigue, pain in shoulder, back and neck. In the discussion with IRC, this is elaborated on as follows: “On a follow up visit in June, she complained about being fatigued and stressed around the other lady’s illness. You provided her 5 mg of Ativan⁵ providing her with five pills.”⁶

[34] The Appellant in reply (again after the hearing) said that Dr. DeWitt had prescribed this a few days before her scheduled appointment with the orthopedic surgeon, to relax her for this.

[35] We have reviewed [document numbers deleted]⁷.

[36] **On the documentation filed, we are satisfied that SGI has demonstrated that there is no medical evidence that this drug was prescribed for an accident-related condition.**

Termination of Massage and Other Passive Therapies

[37] The main topic of the internal review was the July decision to terminate passive treatments referred to Anderson’s report. The decision stated:

⁵ Apo-Lorazepam and Ativan are trade names for the same generic anti-anxiety drug, lorazepam.

⁶ Corroborated by Dr. DeWitt.

⁷ Scott Anderson’s reference June 26, 2002 to “increased stressors at work, due to her cousin’s illness...”

“Health care research indicates that long term reliance on passive treatments for soft tissue injuries is not recommended. Although it is recognized that these types of treatments can provide individuals with short term relief from accident related complaints, they have minimal benefit for long term recovery. Instead individuals are encouraged to pursue a more active regime. Passive treatment is defined as practitioner based treatment that requires no active participation by the patient.”

[38] The Appellant subsequently provided SGI with a note from Dr. McGettigan in Saskatoon dated January 10, 2003: “This lady requires ongoing upper body, neck and shoulder massage.” SGI referred this to its medical consultant, Dr. Jutras, together with Dr. McGettigan’s report that her bone scan⁸ and EMG⁹ were normal.

[39] Dr. Jutras concluded that this information did not indicate that the ongoing concerns were related to the motor vehicle accident¹⁰ and so did not justify a re-institution of massage therapy when the internal review process had decided that this was not warranted.

[40] New medical evidence was filed by the Appellant at the hearing: a report from an orthopedic surgeon¹¹, an MRI of her right shoulder¹², and a report from a neurosurgeon¹³. SGI has not had an opportunity to have these reviewed by its medical consultants, and we do not believe we should attempt to do so.

[41] Since the Commission is looking at all of the evidence (except as noted in paragraph 40) to determine whether SGI’s decision should be confirmed, varied or set aside, we have considered principally Anderson’s reports, Dr. DeWitt’s reports, IRC’s report on the discussion with Dr. DeWitt, the referral to Dr. Jones, the bone scan and EMG studies, Dr. McGettigan’s letters and Dr. Jutras’ opinion. We have concluded that although she has not re-gained her pre-MVA function, and perhaps may never do so, SGI’s responsibility under section 110 of *The*

⁸ September 6, 2002: “Normal whole body bone scan. In particular the right shoulder appears quite normal although there is a history of motor vehicle accident and past surgery with respect to the right shoulder. Minor arthropathy of the right shoulder is seen. Reflex sympathetic dystrophy of the right distal forearm, wrists and hands or the shoulder region or visualized portions of the right arm is not seen.”

⁹ Needle electrode studies and nerve conduction studies right arm.

¹⁰ That is, the ninth MVA, the only one for which SGI is responsible.

¹¹ Dated April 22, 2003.

¹² Dated June 19, 2003.

¹³ Dated August 13, 2003.

Automobile Accident Insurance Act in force at the time of the Appellant's accident (the "old Act") does not require it to fund *all* treatment.

"110(1) In this section, 'rehabilitation' includes any or all of the following measures, programs and treatments that the insurer considers necessary or advisable to contribute to the rehabilitation of a victim, to lessen the victim's disability caused by the accident and to facilitate the victim's recovery from the accident:

- (a) physical and acquired brain injury programs and treatment;
- (b) occupational and vocational training and programs;
- (c) alterations to an victim's residence;
- (d) modification or purchase of a motor vehicle for a victim;
- (e) purchase of special equipment for a victim;
- (f) any additional prescribed measure, program or treatment prescribed in the regulations.

(2) Subject to the regulations, the insurer may take any measure it considers necessary or advisable to contribute to the rehabilitation of a victim, to lessen a disability resulting from bodily injury and to facilitate the victim's recovery from the accident.

(3) The total combined maximum benefits payable to a victim pursuant to this Division and Division 7 is \$500,000 for each accident in which the victim suffers bodily injuries arising out of an accident."¹⁴

[42] As we held in *S.R. v. SGI*¹⁵, in most cases, what is "necessary" will be obvious to all, "advisable" less so. "Advisable" has been defined (Webster's Third International Dictionary) as: "proper to be advised or to be done; expedient; prudent".

[43] We had to consider if (a) the massage therapy and other passive modalities

- (a) contribute to the Appellant's rehabilitation;
- (b) lessen her disability caused by the accident; or
- (c) facilitate her recovery from the accident.

[44] In a letter provided to the Commission after the hearing, SGI noted that they had asked the family physician May 22, 2002 why he had referred the Appellant for massage therapy, for what areas, and the results. His answer was that in response to her request for referral for

¹⁴ Because Nelson was injured before the current *Act* came into force, the 1995 version applies. (The current equivalent of section 110 is section 112.)

massage, he had referred her to physiotherapy, and she had gone to massage therapy and brought him a note. SGI submitted that it did not have evidence that massage treatments were medically required as a result of the accident, and therefore would not be able to provide funding.

[45] The Appellant's reply to the Commission was that she had provided him with Dr. Markland's report of March 20, 2001, which recommended acupuncture and /or massage therapy. Dr. DeWitt had suggested acupuncture, not physiotherapy (which she was already receiving from Anderson). She had wanted a referral from him because otherwise SGI would not pay. She believes that he may have confused these things when signing the IRC letter.

[46] While it appears plausible that a busy general practitioner could overlook a small point of this kind in reviewing IRC's letter, Dr. DeWitt's clinical notes summary for April 2, 2002 ("Pain right arm and shoulder, she was requesting referral to a massage therapist. Refer to Physio."), presumably contemporaneously made, seem clear.

[47] The treatments were not prescribed by the physician treating her at the time the therapy was taken in 2002: they were recommended by Dr. Markland in 2001 and by Dr. McGettigan in 2003. Dr. McGettigan's recommendation does not address the "accident-related" issue.

[48] We do not think (and the evidence does not support) that massage therapy was contributing to her rehabilitation or facilitating her recovery under section 110 (1) or (2) of the *Act.*. An argument can certainly be made that massage therapy *can* lessen disability, but we are not satisfied that there is evidence that massage therapy in the Appellant's case lessens her accident-related disability. When asked, she stated that she hadn't "deteriorated" since the treatments were stopped.

[49] **We confirm SGI's decision of January 9, 2003 on this point as well.**

¹⁵ I, 2003skaia003

Psychological Counselling

[50] In addition, SGI referred the file to Dr. Glenn Pancyr, a registered psychologist, to consider if ongoing psychotherapy with Dr. Chartier was still needed as a consequence of the motor vehicle crash (MVC). Dr. Pancyr outlined the documents he considered particularly relevant in his report of February 10, 2003. He noted that he had been advised by SGI that there was no further documentation from Dr. Chartier since March, 2000, despite numerous requests and despite invoices for psychological sessions approximately twice a month since March, 2000.

[51] Because of his earlier involvement, Dr. Pancyr was aware from Dr. Chartier that the Appellant was not comfortable with personal information going to SGI and that she had longstanding psychological problems underlying her diagnosis of major depression.

[52] He concluded:

“After three years of regular psychological treatment, I can find no reason why the customer should not have completely recovered from the psychological effects of this particular MVC. When one considers standard protocols for treating depression, pain and adjustment to physical limitations and ongoing problems (e.g. surgery), the amount of treatment she has received¹⁶ should be sufficient to ameliorate the MVC related problems. Therefore, without any additional documentation from the treating psychologist, I would conclude that further psychological treatment for the effects of this MVC is not reasonable. I would also conclude that it is not reasonable that she would continue to be clinically depressed to the degree that she would warrant antidepressant medication solely from the effects of this MVC. Were it not for her preexisting psychiatric and psychological history, I would expect any depressive symptoms solely attributable to the MVC to have resolved. Therefore I am concluding that any lingering depression which requires antidepressant medication should be considered entirely due to preexisting conditions.”

[53] Following this letter, SGI wrote the Appellant on February 12, 2003 terminating funding for psychological counselling effective February 19, 2003. The letter also noted “you had advised me in our meeting of January 10, 2003 that no matter what Dr. Chartier advises about relaxation or how much you talk about the accident and related issues, you will not get over this.”

[54] The letter also terminated funding for medication directly related to depression as of the same date.

¹⁶ Approximately 70 sessions.

[55] The Appellant was critical of Dr. Pancyr's report, as with SGI's handling of her file entirely. She suggested his report was influenced by SGI, that her treatment did not follow "standard protocols" and so he should not have applied this reasoning, and that her pre-existing depression was under total control

[56] Dr. Pancyr testified by telephone conference. He is a registered psychologist, with training and experience with chronic fatigue, chronic pain, cognition and pain. He lectures to medical students and psychiatric residents at the University of Saskatchewan on cognitive behaviour therapy for depression. He has done about 250 file reviews for SGI over a four year period on psychological aspects of the insured's care.

[57] He noted that he had been involved in 2000 in connection with recommending counselling to help her go into a tertiary rehabilitation program, which he felt was important for her. On the 2003 file review, he had observed she had attended seventy sessions with Dr. Chartier over a three year period. Without any information from Dr. Chartier as to the extent to which this therapy was assisting on motor vehicle crash issues, he could not recommend continuing treatment. When asked by the Appellant about the "standard protocols", he stated that "uncomplicated" cases, ranging from mild to severe, normally required 20 one-hour sessions. For persistent pain, the Royal University Hospital chronic pain group, with which he works, uses a model of eight weeks — 20 to 30 hours —with substantial gains for the patients. 70 sessions would be more than double this amount. At best, he thought that her ongoing sessions with Dr. Chartier could be characterized as "maintenance" or "preventing a relapse". He agreed with the Appellant that therapy can be slowed if a person is angry with those who administer their benefits, and that decisions made by SGI on her care would cause stress. He said he could not comment on the increased dosage of her anti-depressant medication post-MVA, which she said had gone from 50 mg to 200 mg and then to 300 mg. He agreed that an increase in medication should be considered, but not in isolation. He would not comment on whether the MVA caused the increase in medication, saying that it was "tough to apportion this between a crash and a mood disorder".

[58] The real focus of the Appellant's appeal was not so much disagreement with Dr. Pancyr's report as a detailed critique of how SGI has managed her case. These are set out in [the documents], and we have considered it carefully, together with the supporting documentation to which she referred at the hearing. There was definitely a problem in 2000 regarding tertiary treatment or not, but we believe it was resolved in an enlightened manner (the "augmented secondary treatment").¹⁷ There was also a degree of miscommunication going on during 2002, when the Appellant was in [location], between her family physician, SGI, the physical and occupational therapists and the rehabilitation consultants working on behalf of SGI. In particular, she mentions that her family physician had sent information to SGI that the adjuster claimed she had not received. The documentation on this is incomplete, but it appears that SGI wrote requesting information on May 22, 2002¹⁸, and received a reply to September 10¹⁹. Before then however, IRC had interviewed the doctor August 20, as discussed in paragraph 26, mentioned by Dr. DeWitt in a letter to SGI August 23, advising that when he had the rest of the medical information, he would review it and then send a letter.

[59] As set out above, while we are all of the opinion that while the Appellant has not returned to her pre-accident level of functioning we cannot – in the absence of any evidence at all – conclude that Dr. Pancyr's report of February 10, 2003 is erroneous, based on erroneous assumptions, or unreasonable. **SGI's decision of February 12, 2003 is confirmed.**

[60] The Appellant has other options available: she can authorize Dr. Chartier to provide information to SGI or to Dr. Pancyr if that will resolve his concerns that she requires ongoing counselling and medication as a result of injuries incurred in the 1998 accident. Since she no longer resides in Saskatoon, she can seek supportive counselling through Saskatchewan Health in an area closer to her new home. She can continue her current course of going without counselling, since she says that she wants to try this and her condition is not deteriorating.

Dated at Regina, Saskatchewan, on March 15, 2004.

¹⁷ We do not know — and it is not particularly important — whether this was because of or in spite of an intervention by the Coalition against No Fault.

¹⁸ Document filed by SGI on request after the hearing.

¹⁹ With chart notes, IRC letter (presumably of August 2002), consult reports.

Ann Phillips, Q.C., Chair

Beverly Cleveland, Commission Member

Mukesh Mirchandani, M.D., Commission Member