LICENCE APPEAL TRIBUNAL | **TRIBUNAL D'APPEL EN MATIÈRE DE PERMIS**

Safety, Licensing Appeals and Standards Tribunals Ontario | **Tribunaux de la sécurité, des appels en matière de permis et des normes Ontario**

Citation: Roseanne Salvi vs. CUMIS General Insurance Company, 2020 ONLAT 19-005573/AABS

Released Date: 10/27/2020
File Number: 19-005573/AABS

In the matter of an Application pursuant to subsection 280(2) of the *Insurance Act*, RSO 1990, c I.8., in relation to statutory accident benefits.

Between:

Roseanne Salvi

Applicant

and

CUMIS General Insurance Company

Respondent

DECISION AND ORDER

ADJUDICATOR: **Cezary Paluch**

APPEARANCES:

For the Applicant: Frank A. Calcagni, Counsel

For the Respondent: Peter Durant, Counsel

Heard by way of written submissions

OVERVIEW

[1] The applicant R.S. was involved in an automobile accident on September 17, 2016 and sought benefits pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010* ("*Schedule*").[1] The applicant was denied certain benefits by the respondent and submitted an application to the Licence Appeal - Automobile Accident Benefits Service (the "Tribunal").

[2] The parties participated in a case conference on October 21, 2019 but were unable to resolve the issues in dispute and proceeded to a written hearing.

ISSUES

[3] The following are the issues to be decided which are set out in the Order of Adjudicator Mazerolle released on January 6, 2020 ("Order'"):

i. Is the applicant entitled to attendant care benefits (ACBs) in the amount of $3,192.69 per month for the period of July 11, 2017 to-date and ongoing?

ii. Is the applicant entitled to receive medical benefits recommended by Ross Rehabilitation as follows:

a. $1,089.24 for occupational therapy services in a treatment plan submitted on May 11, 2017, denied by the respondent on May 31, 2017;

b. $4,455.68 for other assistive devices in a treatment plan submitted on November 23, 2017, denied by the respondent on December 14, 2017;

c. $4,455.68 for other assistive devices in a treatment plan submitted on November 23, 2017, denied by the respondent on March 7, 2018;

d. $158.20 for occupational therapy services in a treatment plan submitted on January 23, 2018, denied by the respondent on March 7, 2018; and,

e. $942.95 for occupational therapy services in a treatment plan submitted on January 26, 2018, denied by the respondent on March 7, 2018?

[1] O. Reg. 34/10.

iii. Is the applicant entitled to receive medical benefits for chiropractic services recommended by Dr. Frank Ramelli as follows:

   a. $743.72 in a treatment plan submitted on November 6, 2017, denied by the respondent on December 18, 2017; and

   b. $2,103.72 in a treatment plan submitted on November 16, 2018, denied by the respondent on November 27, 2018?

iv. Is the applicant entitled to interest on any overdue payment of benefits?

Preliminary Issue - Issue 1 – Raised by respondent as being incorrect

[4] The respondent in their submissions state that issue 4 i) regarding ACBs is incorrectly framed in the Order as a monthly benefit and what is in dispute is a treatment plan in the amount of $3,192.69 for a Progressive Goal Attainment Program (PGAP) treatment completed by Jane Zambon, OT, dated April 26, 2017, which was partially approved in the amount of $3,142.69 on July 11, 2017. However, the applicant in her submissions maintains her request for the ACB's of $3,192.69 per month for the period of July 11, 2017 to-date and ongoing.

[5] The parties conducted a case conference where the issues were identified and agreed to on consent. The respondent submits that the framing of this was discussed at the case conference when the applicant undertook to provide particulars of this issue which they say have not been provided. Indeed, paragraph 3(f) of the Order required the applicant to provide the "*Particulars of Issue 1* [the ACBs]" by April 9, 2020. Subsequently, on March 10 and April 6, 2020, in advance of the April 9 deadline, the respondent wrote to the applicant requesting particulars of the attendant care in accordance with the Order. The applicant maintains in her reply that "*her counsel has made its best reasonable efforts to provide the productions that it agreed to provide at the case conference*." Further, that somehow "*it has complied with the Case Conference Report in submitting its documents for the hearing.*" I simply do not accept these arguments that the applicant has complied with para. 3(f) of the Order because I have not been provided with any documented proof that the agreed upon particulars were ever provided prior to the hearing in accordance with the clear wording of the Order.

[6] It is trite to say that Tribunal orders should be followed. As well, cooperation and goodwill amongst counsel with respect to productions, especially when regarding something that was agreed to, plays a crucial role in ensuring a fair and efficient hearing process that affords all parties an opportunity to present their case. I

would have expected that a brief letter confirming the details of the attendant care being sought (ie.name of service provider, rates charged, dates when services were provided) was a reasonable request in these circumstances.

[7] Following the issuance of the Order, there was no motion brought by either party to amend this issue. To be frank, I am not entirely certain how the parties can have such a fundamental disagreement over the framing of a basic issue at this late stage of the proceedings. At the minimum, the applicant should have addressed this issue in their reply submissions once the respondent continued to voice their concern that this issue is incorrectly and/or ambiguously characterized as a monthly attendant care at $3,192.69 per month. Instead the applicant ignored it and merely re-stated her request for relief as contained in its initial submissions at paragraph 25 [ACBs in the amount $3,192.69 per month for the period of July 11, 2017 to-date and ongoing] and as an alternative remedy, at this late stage of the proceedings when submissions have been submitted, requested an adjournment of the hearing to allow the respondent to receive and review the "said records" even though the said records never included the particulars the respondent has been requesting for several months in the first place.

[8] So, what am I to make of this? I address the respondent's request for an adverse finding related to the production order later in this decision. Here, I am guided that it is the applicant's Application and up to her to frame the issues in dispute so long as they are proper accident benefits in dispute that have been denied. The letter of July 11, 2017 is a valid denial of a benefit (ACBs) she was entitled to apply for after her accident. Further, my review of the Application filed to initiate these proceedings is that it identifies the very same issue (monthly ACBs) as in the Order. The applicant's affidavit at para. 16 mentions that her mother and daughters complete the housekeeping tasks that she is unable to do so it appears that she is requesting attendant care on a monthly basis and ongoing. Therefore, although I am mindful of the wording of the Order to provide the particulars and that the respondent does not agree with the framing of the issue, I must be guided by the fact that the applicant maintains her request for ACBs for the period of July 11, 2017 to-date and ongoing and has not consented to have this issue changed.

[9] Therefore, issue 4 i) remains the same as in the Order and I am prepared to adjudicate upon it in its current form with the applicant bearing the onus. I have no jurisdiction to rule upon any other issue that is not before me. I am also not prepared to adjourn this hearing to delay this matter further and somehow allow the respondent to receive and review unspecified information or records and, if it deems necessary, file amended submissions in order to rectify any prejudice.

The respondent has not asked for any adjournment or additional time to review records and file amended submissions.

RESULT

[10] I find that R.S. is not entitled to ACBs for the period in dispute as she has not demonstrated the benefits were incurred for the period in dispute.

[11] I also find that R.S. is entitled to $4,455.68 for assistive devices (mattress) denied on December 14, 2017; and $924.24 for occupational therapy services.

[12] R.S. is not entitled to the remaining treatment plans as they are not reasonable and necessary.

[13] Interest applies on overdue, incurred benefits pursuant to s. 51 of the *Schedule*.

LAW AND ANALYSIS

Attendant Care Benefit (ACBs)

i. *ACBs in the amount of $3,192.69/month from July 11, 2017 and ongoing*

[14] The attendant care benefit is intended to reimburse an insured person for money expended to a professional attendant care provider or a family or friend (ie. lay person). In this case, the respondent started to pay the applicant the ACBs on May 5, 2017 when they received the applicant's Assessment of Attendant Care Needs - Form 1 requiring care services. The respondent formally terminated payment of this benefit effective July 11, 2017 after their own assessor concluded there was no need for attendant care assistance.

[15] Based upon the evidence before me, I find that the applicant's claim for ACBs must be denied. She has simply failed to prove, on a balance of probabilities, that any expenses for ACBs were incurred in accordance with s. 3(7) of the *Schedule*. I also decline to deem any ACBs incurred under s. 3(8) of the *Schedule*. R.S. is, therefore, not entitled to any ACBs for the period sought.

[16] Section 19 of the *Schedule* states that an insurer shall pay for all reasonable and necessary expenses <u>incurred</u> by or on behalf of an insured person as a result of an accident for services provided by an aide or attendant. R.S. bears the burden of proving entitlement to ACBs on a balance of probabilities.

[17] Further, section 42(1) of the *Schedule* states that an application for ACBs must be in the form of a worksheet type document entitled 'Assessment of Attendant

Care Needs' ("Form-1") and contain the required information and submitted to the insurer by an occupational therapist or a registered nurse. The amount or quantum of the monthly ACBs is determined in accordance with this worksheet based on calculating what services are required. There are three categories of care, levels 1, 2 and 3. Level 1 is for routine personal care. Level 2 refers to care for basic supervisory functions such as hygiene and self-sufficiency in emergency situations. Level 3 is for more complex health care. Defining the attendant care needs of the applicant is the purpose of the Form 1, but customarily it is another Superintendent approved form called the Expense Claim Form (OCF-6)[2], or similar type document like an invoice, which triggers ongoing payments. It seems to me without any OCF-6's or similar type document no ongoing payments can ever be triggered because the insurer will not know what expenses have been accrued.

[18] Section 3(7) provides further guidance on when an expense is incurred. In order to qualify for ACBs, R.S. must also establish that the services were "incurred", which involves 3 components that must be addressed. They are:

(1) the applicant must have received the disputed benefit;

(2) there must be a promise to pay the service provider(s) for work completed (ie. legal obligation); and

(3) if the service provider is a "lay person", they must have sustained an economic loss as a result of providing attendant care services, or if not a lay person, the provider of attendant care services must be providing these services in the course of their regular profession.

[19] In this case, the respondent refuses to pay any ACBs because it is not satisfied that the applicant has shown that any expenses were incurred as no OCF-6 or invoice was submitted by the applicant to be considered for reimbursement. There has been no proof of the precise services provided to R.S., by whom and on which dates. I agree and accordingly her claim for ACBs should be dismissed.

[20] The applicant relies upon a positive Form-1 dated March 28, 2017, accompanied by an Occupational Therapy In-Home Assessment Report dated May 4, 2017 that was submitted by Jane Zambon, OT. In the Form-1, Ms. Zambon, concluded that R.S. required assistance with the following tasks: shaving, cosmetics; toenail care; assistance with feeding; hygiene consisting of cleaning the bathroom and

[2] See s. 66 of the *Schedule* requires that each the following documents shall be in a form approved by the Chief Executive Officer (formerly the Superintendent of Financial Services): An invoice in respect of an expense for goods or services specified in a Guideline applicable for the purposes of section 49.

changes of bedding; and assistance with basic supervisory care. Ms. Zambon determined that R.S. required $997.54 per month of ACBs.

[21] When reviewing the applicant's Form 1, I queried how the applicant was requesting $3,192.69 per month for ACBs when this form only recommended $997.54 per month – less than 1/3 of the amount sought and as framed in this issue. My reading of section 19(2) of the *Schedule* is that it establishes, subject to legislated limits, that the maximum amount payable for a monthly ACB is established by the Form 1. There is no other Form 1 from any person recommending the $3,192.69 monthly amount. No explanation was provided by the applicant for this discrepancy or the basis for claiming the $3,192.69 or how this much higher monthly figured was ever calculated in conjunction with the three categories of care. As there are no other Form 1s at all, I consider the amount of $997.54 to be the maximum monthly amount payable for the ACBs as part of this application.

[22] Further, the respondent denied the ACBs on July 11, 2017 for two reasons. No OCF-6 or invoices were ever submitted, and the applicant did not actually need ACB's based on the IE Occupational In-Home Assessment report completed on June 30, 2017, and Form 1 dated June 15, 2017 by Rita Wilson, OT. Ms. Wilson noted that the applicant has sustained soft tissue injuries and concluded there was no need for attendant care assistance – although she acknowledged that R.S.'s participation in certain tasks was not without pain. During the assessment, the applicant presented with adequate cognition, range of motion, muscle strength and functional abilities to complete her pre-accident self care routine. As a result, Ms. Wilson determined that R.S. required $0.00 per month of ACBs.

[23] The applicant submits that, as result of the accident, she has developed neck and bilateral shoulder, headaches, left arm, back, left hip, and foot pain and also developed cognitive difficulties including light sensitivity, fatigue, reduced memory and trouble concentrating. She states in her affidavit that, prior to the accident, she was independent in all activities of daily living including personal care and housekeeping and, since the accident, she has had to modify these activities. In the months immediately following the accident, she was unable to complete any of her housekeeping tasks and family and friends assisted her with shopping. Currently, she deposes, at paragraph 11 of her affidavit, she has resumed most of her housekeeping duties although they take longer to complete and cause pain.

[24] RS's affidavit is brief and vague. She asserts that she experiences headaches, physical pain, cognitive problems and emotional issues and currently she is no

longer able to cook large meals or clean up after meals without great difficulty. She also asserts that immediately following the accident she was unable to complete any housekeeping duties including cleaning, cooking or shopping and she relied on her friends and family to help with shopping and bringing meals to her home. Although she has resumed most of her housekeeping duties which she explains take her much longer to complete and cause her pain.

[25] I find RS's affidavit to be unhelpful to her case because it lacks specific details. There is no breakdown of services listed, times, duration, level of care, no time dockets or job diaries attached as exhibits, and this document cannot be characterized as an invoice for ACBs under the most generous definition even though no cross examination ever took place. These factual details are critically important to the determination of this issue. It informs whether the services provided correspond with any expense claim forms that normally are submitted to the insurer. I wanted to know if it was 2 or 3 days and the name of the person who apparently provided any attendant care services to her. How else can an insurer know what amount is to be reimbursed as the level of services may change from month to month? In fact, nothing in her affidavit suggested the applicant required any attendant care during the period in question as there are no dates included anywhere. In my view, the affidavit alone on its own is not compelling evidence in support of an attendant care benefit.

[26] As well, there is no contemporaneous evidence from a doctor that shows the applicant to have limitations and restrictions that would suggest she requires assistance with her activities of daily living at the level of her Form 1. I am not directed to any clinical notes and records of any treating practitioner such as her family doctor in support of functional limitations that would warrant the need for ACBs.

[27] After reviewing the applicant's affidavit and other documentation in evidence for the written hearing, I find there no such expense forms or other accounts that might have provided this necessary information. There are simply no invoices or breakdown of services, no promissory notes, no affidavits or statements from any service provider speaking to services provided to her, the level of care, the rate of care, the exact dates worked per month or the number of hours worked per day. etc.

[28] Also, the Form-1 by Ms. J. Zambon is also problematic because she recommended 90 minutes a day (or about 10 hours a week) for supervisory care in her Form 1 because R.S. apparently lacked the ability to respond to an emergency or needs custodial care due to changes in her behaviour. I did not

understand why 10.5 hours per week was needed for the applicant to be supervised when she was living with her husband and children who could respond to any emergency. It also appeared to me that from the medical evidence that the applicant was able to exit the home herself in case of an emergency and this estimation of services was excessive. She returned to working in late 2017. Most importantly, her affidavit did not speak to any needs she was having with supervision.

[29] Similarly, the applicant's written submissions also do not refer to the name of a service provider who provided any attendant care services to the applicant. No documentation has been provided evidencing that R.S. has in fact paid the expenses for the service provider or any person sustained an economic loss as a result. Accordingly, as it is R.S.'s burden, the Tribunal has no basis on which to find that she received any such goods or services, that she has paid any ACB expenses, has promised to pay the expenses or is otherwise legally obligated to pay the expenses. Finally, since the applicant has failed to satisfy the criteria in s. 3(7)(e) it is therefore unnecessary for me to consider hypothetically what quantum of attendant care benefits would have been justified as reasonable and necessary in this case.

[30] For completeness, section 3(8) of the *Schedule* states that the Tribunal may, for the purposes of determining an insured person's entitlement to a benefit, deem the expense to have been incurred if it finds that the insurer unreasonably withheld or delayed the payment of a benefit in respect of the expense. My reading of this section is that it deals with the conduct of the insurer. It is not meant to waive the requirements of section 3(7). Here, the applicant has not advanced any arguments, analysis or evidence how CUMIS unreasonably withheld or delayed payment of ACBs other than stating in a general way that these benefits were wrongly denied and contradicts the medical evidence. I am not prepared to make any such findings to justify deeming attendant care incurred. To the contrary, the evidence demonstrates that CUMIS acted reasonably and moved as quickly as possible after receiving the applicant's Form-1 (May 5, 2017) by starting to pay the benefit and wrote to the applicant (May 8, 2017) advising that they do not agree that the Form 1 correctly reflects R.S.'s attendant care needs and they would be scheduling a s. 44 assessment which was conducted on June 15, 2017 with a report completed on June 30, 2017.

[31] Moreover, to date, the applicant has not provided any invoices to the respondent for the attendant care services for the period that CUMIS agreed to pay. More to the point, it appears that R.S. never had any attendant care expenses for which

she should have been reimbursed through ACBs in the first place. In this light, R.S.'s plea for ongoing ACBs without any invoices or proof of any incurred expenses is brash, to say the least. Not satisfied with having already received ACBs for services that were not provided or provided for free, certainly without any invoices or proof of economic loss if it was a lay person, she now demands that CUMIS continue to fund the same windfall on an ongoing basis. It would have been an entirely different situation if the applicant informed the respondent who was attending to her needs and provided particulars. As indicated above, she did not provide this information. Given that the applicant has not provided sufficient information with respect to attendant care services, even to the present date, and given that I do not find the respondent acted unreasonably by withholding or delaying payments, I find the applicant cannot rely upon the deeming provision in s. 3(8). In the result, the claim for ACBs is dismissed.

Medical and Rehabilitation Benefits

[32] Sections 14 and 15 of the *Schedule* provide that the insurer shall pay medical benefits to, or on behalf of, an applicant so long as the applicant sustains an impairment as a result of an accident and the medical benefit is a reasonable and necessary expense incurred by the applicant as a result of the accident.

[33] R.S. bears the onus of proving her entitlement to the claimed treatment and assessments by proving they are each reasonable and necessary on a balance of probabilities.[3]

[34] For the reasons that follow, I find that R.S. is entitled to the following two OCF-18s:

i. $4,455.68 for other assistive devices (mattress); and

ii. $924.24 for occupational therapy services.

[35] R.S. is not entitled to any of the remaining treatment plans in dispute

Ross Rehabilitation Proposed Treatment

a. $1,089.24 for occupational therapy services OCF-18 dated May 11, 2017

[36] This treatment plan in the amount of $3,290.06 for a gym membership and kinesiology sessions was partially approved in the amount of $2,200.82. The

[3] *Scarlett v. Belair Insurance*, 2015 ONSC 3635 (CanLII) at paras. 20-24.

respondent approved 8 – 1-hour kinesiology treatments (opposed to the 3-hour sessions proposed) which they say was excessive.

[37] The applicant in her submissions concedes that she is no longer seeking payment of $140.00 for mileage but requests that the balance of $924.24 ($1,089.24 - $140.00) in denied treatment be paid. The applicant submits that the insurer did not provide any reasoning or medical basis for its partial denial. I agree.

[38] Sections 38(8) of the *Schedule* sets out notice requirements for insurers responding to treatment plans, with specific consequences if they fail to comply. Under section 38(8), the insurer must notify the insured person within 10 business days whether it will pay for the goods and services requested. If it refuses to pay for them, it must state the medical and other reasons why it considers the goods and services not to be reasonable and necessary. These are matters that are exclusively within the control of the insurer and are mandatory.

[39] In my view, the use of the words "*medical reasons and all other reasons*" in s. 38(8) imposes additional obligations and prevents insurers from denying treatment arbitrarily and ensures that the insured person has enough details and particulars about the denial to make an informed decision whether to either accept or dispute the decision at issue.

[40] On May 11, 2017, R.S. submitted a treatment plan in the amount of $3,290.06 for occupational therapy services. By letter dated May 31, 2017, the respondent denied this treatment plan and explained [in part] as follows:

> *We are receipt of the Treatment and Assessment Plan (OCF-18) as submitted by Brooke Alexander of Ross Rehabilitation in the amount of $3290.06. Please be advised that we have partially approved this OCF in the amount of $2200.82.*
>
> *We have approved 8-1 hour kinesiology treatments (exercise program overview) opposed to the 3 hour sessions proposed,* ***which appears to be quite excessive in comparison to treatment being provided.*** *[emphasis mine]*

[41] My review of this denial letter is that it falls short of the mark required by s. 38(8) as well as the principles enunciated by the Tribunal in *16-03316/AABS v. Peel Mutual Insurance Company*.[4] Here, the respondent simply explained to the

[4] *16-03316/AABS v. Peel Mutual Insurance Company*, 2018 CanLii 39373 (ON LAT).

applicant that the proposed treatment "*appears to be quite excessive in comparison to treatment being provided.*" However, the respondent offered not a single "medical reason" and did not reference R.S.'s condition or refer to any of her diagnoses in this denial. Moreover, in furtherance of the principle in *Peel Mutual*, that the "medical and any other reasons" should be clear and sufficient enough to allow an unsophisticated person to make an informed decision to either accept or dispute the decision at issue, the mere reference to the plan appearing excessive without any explanation why it was excessive and what the words "comparison to treatment" mean is insufficient. In other words, if the insurer felt the proposed sessions were excessive, they must explain with some basic detail why. Certainly, a reference to any accepted guidelines or industry practices would be of assistance (as was done in the March 7, 2018 denial letter). Alternatively, if there was missing information required by CUMIS then this also should have been communicated to R.S. in a clear way.

[42] For these reasons, I find that the respondent failed to satisfy its obligation under s. 38(8) of the *Schedule*. As a result of the lack of proper notice, the mandatory consequence outlined in s. 38(11) of the *Schedule* applies. Specifically: the insurer is required to pay for the goods and services set out in the treatment plan until a proper notice is given starting on the 11th business day after the insurer received the application and ending on the day the insurer gives a notice described in this subsection. I have no information that any other notice was given. The respondent must pay the balance of this treatment plan. I need not determine whether the benefits in dispute are reasonable and necessary.

b. $4,455.68 for other assistive devices (mattress) denied on December 14, 2017

[43] I find the medical benefit for a trialed and supportive mattress including mattress protector and base to be reasonable and necessary. I find it clear on the evidence that R.S. suffers from disturbed sleep and pain as a result of the accident. Her complaints are consistent and continuous in the medical documentation before the Tribunal and are confirmed in the reports and notes of several of her medical practitioners.

[44] The applicant submits that this treatment plan was for a trialed and supportive mattress to assist the applicant in her recovery as recommended by the applicant's occupational therapist. The respondent denied this treatment plan based on an OT IE report of Nancy Rushford, which also referenced a prior IE report of Dr. Stacey, physiatrist, holding that the proposed plan is not reasonable and necessary to address any impairments resulting from the accident.

[45] The OCF-18 requests the following goods and services: mattress ($2,719.99); base/mattress protector ($869.99); planning service ($99.75); and documentation ($99.75). The treatment plan identifies its goals as pain reduction and facilitate restorative sleep patterns. It also identifies that, functionally, the goal is to return to activities of normal living, improve functional independence and reduce the risk of further disability. These goals, in my view, are reasonable given her physical and psychological impairments so she may save her energy and better focus on her pain management strategies. I also find the cost of the mattress to be reasonable to achieve the stated goals. In my view, the potential for restorative consistent sleep can only have a positive impact on her mental health and faster potential recovery.

[46] The Occupational Therapy PGAP Termination Report prepared by Padma Arathi and Jane Sambon, OTs, strongly recommends the mattress to assist with achieving restorative sleep patterns which, in turn, will reduce fatigue and increase her ability to participate in activities. This report is very detailed and comprehensive and links the applicant's symptoms regarding sleep disturbance with the need for an orthopedic or special type of mattress and how it will assist her in her recovery as part of a multidisciplinary approach to treatment. I see no reason to depart from it. As well, the evidence shows the applicant has trouble sleeping and pain as a result of the accident. Her affidavit speaks to limitations of movement in neck, shoulder and fatigue which did not exist prior to the accident.

[47] I am also mindful that this accident occurred several years ago in September 2016 and the applicant still continues to experience these symptoms including pain. It is well settled that pain reduction is a legitimate goal for an assistive device like a mattress. The respondent's own assessor, Danielle Wilson, OT, concluded in her In-Home Assessment of June 20, 2017 that R.S.'s participation in tasks is not without pain and she currently reports sleeping 4 hours a night/waking 3 times (versus 8 hours a night, pre-accident) and comments that she may need to re-adjust her pillow, try heating pads and take sleeping aid medication. Important for me is a recognition that R.S. is having difficulty with her sleep and several recommendations were offered trying to find a solution.

[48] For these reasons, I find R.S. is entitled to the cost of the mattress, protector and base recommended by Ross Rehabilitation, as it is reasonable and necessary.

c. $4,455.68 for other assistive devices denied by the respondent on March 7, 2018

[49] The applicant did not make any submissions regarding this treatment plan for assistive devices. I have no evidence before me how this proposed plan is

reasonable and necessary. It appears this plan was a duplicate of the plan denied on December 14, 2017 for the mattress. I have nothing else to add.

d. $158.20 for occupational therapy (mileage) services submitted on January 23, 2018

[50] The applicant withdrew this issue in her main submissions, which she submits was for mileage ($140 plus HST).[5] The original amount of the plan in the amount of $2,386.06 was approved for $2,227.86 except for the mileage of $140.00 (see Respondent's submissions above para. 48 and denial letter March 7, 2018) which the applicant has now withdrawn.

[51] To be frank, despite my efforts to decipher this information, I was still a little confused between the January 23 and 26, 2018 treatment plans (issues 3 (ii) d and e) as the denial letters were included under the same tab dates and did not exactly match up with the exhibits. It would have been helpful, especially in a written hearing format such as this, to frame each issue to include the necessary particulars of each plan (original amount, approved amount and balance in dispute and what exactly the remaining disputed amount relates to). For example, the dispute amount of $140.00 in issue d. was for mileage, not occupational therapy as set out in the Order. Further, there were three denial letters--all dated March 7, 2018--related to two plans all put under the same tab. Finally, Tab 11 of the Applicant's Exhibit Book referenced the OCF-18 dated January 26, 2018 but contained the OCF-18 dated January 23, 2018 in the amount of $2,386.06.

e. $942.95 for occupational therapy services submitted on January 26, 2018

[52] This treatment plan in the amount of $2,302.20 for occupational therapy was partially approved in the amount of $1,359.25 leaving the balance of $942.95 in dispute. My understanding is that there were two denial letters sent both dated March 7, 2018. The respondent inadvertently made an error in the first letter (incorrectly approved $1,758.25) and sent a second denial letter on the same day (approved $1,359.25). The second letter was to correct the first as there was an error in the approved amount.

[53] The applicant concedes $40 for the mileage in the plan but requests the balance of $942.95 because the applicant provided no basis for the denial. She also argues that this treatment plan was for assistive devices and occupational therapy to assist the applicant in her recovery and activities of daily living including the tasks of her employment. The respondent submits that it provided a

[5] See paragraph 16 of the applicant's submissions.

valid denial and argues that the applicant provided no evidence or argument why the denied treatment plan is reasonable and necessary.

[54] I agree with the respondent on this issue. On the evidence, I find that R.S. has not satisfied her onus and is not entitled to payment for the balance of this treatment plan in dispute as it is are not reasonable and necessary.

[55] First, the applicant provided no explanation or any specific details how the denial failed to satisfy any provision in the *Schedule*. She did not cite any case law of Tribunal decisions to support her position. Merely stating that the denial provided "no medical evidence nor cites any section in the SABS" is not sufficient. What section did the insurer need to cite? Strictly speaking, my view is that the respondent need not provide "medical <u>evidence</u>" in its denial. My reading of both denial letters, which should be read together as they related to the same plan, is that they adequately explained the reason for partial approval, cited the relevant provision from the Professional Service Guidelines and explained that expenses are payable according to the professional fees as specified in the Guideline and insurers are not liable for any other administrative or other related fees.

[56] Second, unfortunately the applicant did not explain what assistive devices she requires and how it will help. Her affidavit does not mention any assistive devices that she apparently needs to assist with her recovery and for her specific impairments. She generally mentions that this treatment plan will help her with her activities of daily living but does not specify what activities and why. More importantly, the applicant does not point me to any corroborating medical evidence to support her position. Merely stating that a s. 44 report by Danielle Wilson noted that the applicant required various assistive devices without stating what they were is not sufficient. The Tribunal would have benefitted from a more substantive and tailored discussion of the denied portion of the OCF-18 to demonstrate why the cost is reasonable (ie. there is no stated purpose why each one-hour session requires one hour of planning and one hour to prepare a report after each session) and why it is necessary.

[57] Accordingly, where there is limited analysis of the treatment plan and where there is limited evidence that treatment is helping, and that the proposed entire costs of the plan appear not to be in accordance with the Professional Service Guideline, I find, on a balance of probabilities, that the treatment in dispute is not reasonable and necessary.

Dr. Ramelli Proposed Treatment Plans For Chiropractic Services

a. *$743.72 in a treatment plan submitted on November 6, 2017, denied by the respondent on December 18, 2017; and*

b. *$2,103.72 in a treatment plan submitted on November 16, 2018, denied by the respondent on November 27, 2018*

[58] I will address both these two plans together as they were recommended by the same chiropractor and denied based on the reports of the same IE assessor. Both parties' submissions also discuss these plans together.

[59] The first OCF-18 dated November 6, 2017[6] requests: therapy multiple body sites; and documentation. The second OCF-18 dated November 16, 2018 also requests therapy (multiple body sites), documentation, and arranging treatment.

[60] The applicant submits that both these plans are reasonable and necessary because the applicant continues to have ongoing pain and limitation. She also points out that both were incurred as evidence by the outstanding account with the service provider.[7]

[61] The respondent denied both treatment plans based on the reports of Dr. Paul Stacey. Dr. Stacey in his Physiatry Paper Review Report dated December 6, 2017 noted uncomplicated soft tissue injuries and concluded that, from a physical perspective, the Treatment Plan in the amount of $743.72 was not reasonable and necessary and the applicant should continue with a self-directed exercise program. In arriving at his conclusion, Dr. Stacey also relied on a Physiatry Assessment dated August 17, 2017, to determine the applicant's entitlement to income replacement benefits.

[62] I find R.S. is not entitled to payment for these two treatment plans as they are not reasonable and necessary for the following reasons.

[63] As a starting point, in a written hearing such as this, it is imperative that the applicant provide persuasive analysis and pinpoint reference to the evidence. Merely reproducing the treatment plans without an analysis or directing the Tribunal to the evidence in support of their argument is generally insufficient to meet the insured's burden of proof.

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[6] Tab 13 of Applicant's Exhibit Book contains only pgs. 1-6 of 9 of the November 6, 2017 Treatment Plan.
[7] See Tab 14 of Applicant's Brief – Statement of Account with Redhill Physio and Chiropractic

[64] Here, the applicant's submissions lacked any analysis of how the claimed treatment plans were reasonable and necessary to address R.S.'s alleged injuries. There also seems to be some duplication of services. Aside from Dr. Andrew Gomes-Vargas's report, the applicant's counsel did not direct me to specific medical evidence to support her claims. I found nothing persuasive in his appended documentation to assist me.

[65] I also put limited weight on Dr. Gomes-Vargas's report dated August 21, 2017 because Dr. Gomes-Vargas's assessment did not address the two treatment plans in dispute in this issue. At page 9, Dr. Gomes-Vargas only reviewed the treatment plans of May 11, 2017, April 26, 2017 and February 16, 2017. This is because his report of August 21, 2017 was written before both plans were submitted (November 6, 2017, and November 16, 2018). In other words, his report could never have addressed these two treatment plans. Dr. Gomes-Vargas's examination lasted only one hour, and he did not review any other medical information as part of his report including any pre-accident notes (aside from the three treatment plans mentioned). Dr. Gomes-Vargas appears to diagnose PTSD and then defers his opinion to a mood disorder specialist. He confirms that further testing is required to confirm his findings including an MRI of the cervical spine. I was not directed to any MRI. As well, Dr. Gomes-Vargas recommended physiotherapy and massage therapy and not chiropractic treatment. The disputed treatment plans are for chiropractic treatment.

Adverse Inference - Non-compliance with Production Order

[66] The respondent submits that the applicant has collateral benefits with Green Shield and Great West Life and neither policy has been produced, as well as other productions despite the Tribunal case conference Order dated January 6, 2020. Paragraph 3 required the applicant to provide the collateral benefits files, and medical records[8] by April 9, 2020. After the case conference, the respondent also requested in writing several times that the applicant comply with its production obligations. On this basis, the respondent requests that an adverse inference be drawn.

[67] In reply submissions, the applicant submits that she made best reasonable efforts to provide the productions that it agreed to provide at the case conference. The applicant further explains that her counsel wrote to the respondent on March 12, 2020 enclosing its enclosure letter and Disbursements

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[8] Updated clinical notes and records from GP; updated clinical notes and records from all treating physicians/specialists; decoded OHIP summary (from two years pre-accident to date); collateral benefits files, including LTD/STD files; Employment files; and, Particulars of Issue 1.

Account dated March 12, 2020 (ie. part of the applicant's law firm's statement of account to the applicant for their services rendered)[9] so it could pay to obtain the documents requested by the respondent and that "it is not the applicant's responsibility pursuant to the [*Schedule*] to bear the costs to obtain documentation requested by the respondent." I am not certain what section of the *Schedule* counsel is referring to in these submissions that requires an insurer to pay for the costs of agreed upon arguably relevant productions. Moreover, these documents were to be requested by the applicant as they are within her control and provided to the respondent. The Order did not speak to the respondent being responsible for the costs of these productions.

[68] My review of the March 12, 2020[10] correspondence and attached disbursement account issued by the applicant's law firm is that the applicant's counsel requested the amount of $1,239.65 to be paid to their law firm prior to releasing these documents.[11] The letter states to "kindly remit payment at your earliest convenience and our office will produce a CD copy of same upon receipt". These documents were only produced in reply, so the respondent did not have an opportunity to respond to the March 12, 2020 correspondence. There were no invoices attached from the different treating providers to verify the fees being requested in the Disbursement Account to be reimbursed. It appears that this account was never paid by the respondent. In any event, I do not need to hear anything further from the respondent.

[69] As stated previously, Tribunal orders should be followed. This is especially certain in circumstances when orders are issued on consent – as here - where both parties agreed to its terms. When they are not, there should be consequences if either party has been prejudiced by the non-compliance. Here, the respondent submits that there are serious evidentiary issues with respect to R.S.'s pre- and post-accident treatment and health. The respondent submits R.S. has not produced her treating medical records including her family doctor or any OHIP summaries or her collateral benefits file and asks for an adverse inference to be found. I do note that the Disbursement Account lists the CNRs of Dr. Mandy Tam, the applicant's family doctor from 2011-2015 (pre-accident), which have not been produced and were never included in the applicant's exhibit book (some CNRs post accident have been produced). I note that there is essentially no medical evidence before me at this point for the period prior to the accident

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[9] See Tab 17 – Applicant's Reply Submission
[10] Tab 16 – Applicant's Reply Submissions.
[11] See Tab 16 of Applicant's Reply Submissions - enclosure letter dated March 12, 2020.

(ie. family doctor CNRs and OHIP summaries). The importance of such evidence to a Tribunal's decision is apparent.

[70] Most of this documentation is standard and regularly produced in a medical benefit claim such as this to allow an insurer to adequately assess and adjust the file. Plainly, the Order also did not require the respondent to cover any costs related to producing this documentation. Although, perhaps, the insurer was open to covering reasonable costs, they likely were not willing to cover $1,239.65.

[71] In a situation where when documents or evidence is available or could be made available but not produced then an adverse inference can be drawn in the absence of a satisfactory explanation. The adverse inference is drawn not merely from the failure to produce, but also from failure to comply with the productions Order.

[72] In my view, here, the applicant did not provide a legitimate explanation. In Reply, the applicant attempted to explain that it made best efforts to provide the productions or that the respondent failed to respond to its request for payment for the records the respondent requested, therefore causing the applicant to draw the reasonable inference that it no longer required such documentation.

[73] I simply did not understand, nor accept, how applicant's counsel, on the one hand says they made best efforts to provide the productions and/or that they presumed they were no longer required and then says that they were willing to provide the documents but only upon payment of its account and they are not responsible for the respondent's failure to respond to a request for payments. There are other explanations in the Reply, none which I find satisfactory as the applicant had plenty of time to comply with the Order and it appears that the only reason they did not was that they wanted to be reimbursed for the costs prior to releasing these arguably relevant documents.

[74] In the end, the Tribunal was prevented from having the ability to review the applicant's complete CNRs from her family doctor, OHIP summaries, hospital records and other potentially relevant documentation to evaluate her case. The respondent was also prevented from reviewing and relying upon these documents and may have been disadvantaged regarding raising causation issues or addressing any priority claims disputes with R.S.'s collateral benefits provider - Green Shield and Great West Life.

[75] Such documentation is especially imperative in this case when the applicant claims to have serious ongoing injuries several years after the accident and the

hearing is being held in writing without any *viva voce* evidence. In other words, the prejudice cannot be cured by merely calling a witness (ie. family doctor) and asking questions. The frailties of evidence in support of R.S.'s claim including the applicant's affidavit, which I found cursory and lacking details in many areas, without any supporting attached exhibits/documents to collaborate her statements failed to satisfy the evidentiary burden of proof for these two treatment plans.

[76] I am cognizant of the fact that, in some cases, some documentation may not exist, but, here, it appears that they did exist but were never provided because of a dispute over fees. It is concerning that some of this information was not even included as part of the applicant's brief. Nevertheless, in my view, the applicant's failure to comply with the Order (despite having these records in the applicant's lawyer's possession) further demonstrates a consistent effort by the applicant to frustrate the adjudicative process and a total disregard to cooperate with the insurer in the adjusting of her claim. In the end, in my view, this significantly compromised the applicant's case on its own and I draw such an adverse inference in this case. To be clear, this was not the only basis for disallowing the applicant's treatment plans, it went to my overall assessment of the evidence, and at most I used it to support my decision.

[77] Finally, I point out that despite these deficiencies in the presentation of the applicant's case, I awarded the treatment plan for the mattress because I found consistent medical evidence with a high degree of corroboration with respect to the requested items which likely will assist the applicant in her recovery without further delay. The remaining approved plan for the balance of $924.24 was granted only on a technical breach of the *Schedule* with respect to the denial letter.

Interest

[78] Having determined that certain benefits are payable, it follows that interest applies pursuant to s. 51 once the benefits are incurred.

CONCLUSION/ORDER

[79] R.S. is not entitled to ACBs for the period in dispute as she has not demonstrated the benefits were incurred.

[80] R.S. is entitled to the treatment plan in the amount of $4,455.68 for assistive devices and the balance of the treatment plan in the amount of $924.24 for

occupational therapy services. Interest applies on overdue, incurred benefits pursuant to s. 51.

[81] I find R.S. is not entitled to the remaining treatment plans as they are not reasonable and necessary.

Released: October 27, 2020

Cezary Paluch
Adjudicator