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

Date: 2017-11-07
Tribunal File Number: 17-002301/AABS
Case Name: 17-002301 v The Personal Insurance Company

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

Between:

Applicant

Applicant

and

The Personal Insurance Company

Respondent

DECISION

ADJUDICATOR: **Christopher A. Ferguson**

APPEARANCES

For the Applicant: Lisa Bishop, counsel

For the Respondent: Pamela Vlasic, counsel

HEARD in Writing on September 18, 2017

OVERVIEW

[1] This is an Application to the Licence Appeal Tribunal (the "Tribunal") in respect of an insured person's entitlement to statutory accident benefits or in respect of the amount of statutory accident benefits to which an insured person is entitled.

[2] [ ], ("the applicant") was injured in an automobile accident on August 7, 2014, and sought benefits pursuant to the *Statutory Accident Benefits Schedule – Effective September 1, 2010*[1] (the "*Schedule*").

[3] The applicant has received some treatment for her injuries and now requests a chronic pain assessment ("CPA"), which the respondent has denied. She is appealing the respondent's denial because she argues that the respondent did not follow the steps required by the *Schedule* for denying her claim, including timely notice of denial and the reasons for its decision to deny her claim.

[4] A case settlement conference held on July 5, 2017 failed to resolve the issues in dispute. A written hearing was ordered to take place on September 18, 2017.

DISPUTED BENEFITS

[5] The issues to be decided by the Tribunal are:

1. Is the applicant entitled to the cost of a chronic pain assessment ("CPA") in the amount of $2,000.00 recommended by Prime Health Care in an OCF 18 dated February 5, 2016 and denied on February 25, 2016 because the respondent's denial of the disputed benefit, set out in explanations of benefits ("EOBs"), failed to comply with s.38 of the *Schedule*?

2. Is the applicant entitled to the cost of the disputed CPA because she has proven that it is reasonable and necessary?

3. Is the applicant entitled to interest on any overdue payments from the respondent?

4. Is the applicant entitled to costs?

FINDINGS

[6] The respondent's EOBs complied with the requirements of s.38 of the *Schedule*; it is not liable to pay the applicant's claim under s.38(11).

[7] The applicant has not proven that the disputed CPA is reasonable and necessary.

[1] O.Reg. 34/10.

[8] The applicant is not entitled to interest on overdue payments from the respondent.

[9] There is no basis on which to award costs in this matter. Request denied.

REASONS

Sufficiency of Denial

[9] Section 38 of the *Schedule* prescribes the steps that an insurer must take to notify an insured person of its decision whether or not to pay for treatment and assessment plans. It sets out the required contents of such notices and the timelines for providing them to the insured person:

i. Section 38(8) requires the insurer to give the insured person a notice that identifies, among other things, what elements of the assessment plan it agrees to and what it refuses to pay, with medical and all other reasons why the insurer considers refused goods, services assessment and examinations, or their costs, not to be reasonable and necessary.

ii. The notice required by s.38(8) must be given within ten business days after the insurer receives a treatment and assessment plan.

iii. Section 38(11) of the *Schedule* requires an insurer to pay for all goods, services, assessments and examinations described in the treatment and assessment plan that relate to the period starting the 11th business day after the insurer received the application and ending on the day the insurer gives a notice as prescribed in s. 38(8).

iv. Section 38(13-14) of the *Schedule* governs the steps an insurer is to take after receiving an insurer's examination ("IE") report[2] for the purpose of a proposed assessment plan, namely, within ten business days, the insurer must:

(a) provide the insured person and the regulated health professional who prepared the assessment plan with a copy of the IE report within ten business days of receiving it, and

(b) provide the insured person with a notice indicating the goods and services […] it refuses to pay for and the medical and any other reasons for its decision.

[2] i.e. an insurer's examination conducted under s.44 of the *Schedule* to determine whether claimed medical benefits are reasonable and necessary.

[10] The applicant submits that the Tribunal should set aside the respondent's denials of her claim for a chronic pain assessment as insufficient, because its EOBs did not meet the requirements of s.38 of the Schedule.

[11] The respondent submitted that I should not consider the applicant's arguments about the sufficiency of its EOBs or compliance with s.38 of the *Schedule*. It contends that the applicant seeks to add a "new" issue to the dispute, and that it was obliged to raise these concerns at the case conference stage of these proceedings.

[12] The issue set out in the Tribunal's Order of July 5, 2017 reads:

> Is the applicant entitled to recover the cost of an examination in the amount of $2,000.00 for a chronic pain assessment conducted by Prime Health Care Inc. in a treatment plan submitted February 23, 2016 and denied by the respondent on February 25, 2016?

[14] I reject the respondent's bald assertion that "sufficiency of denial" is a "distinct issue", "separate and apart" from "entitlement to a benefit". It offers no basis for this contention.

[15] The respondent cited the case *J.S. and RBC Insurance,*[3] to support its argument that the applicant has added a wholly new issue, I find the case unpersuasive because the adjudicator in that case did not engage the issue of whether an argument about sufficiency raised for the first time in the initial submission was "new" or "too late". He simply noted that without an objection from the respondent, he would and in fact did proceed to address the merits of the sufficiency of denial issue put before him.

[16] I find that the description of the issue in the Order is wide enough to allow the applicant to establish her entitlement to the disputed benefit on any basis consistent with the criteria set out in the *Schedule*, and s.38(11) is one such criterion.

[17] I find that the initial submission stage of this proceeding is early enough for the applicant to raise the issue of compliance or sufficiency of denial. Accordingly, I will consider whether the EOBs issued by the respondent were or were not sufficient according to the prescribed criteria.

[18] The respondent also contends that, even if its EOBs are found to be insufficient, the applicant must still prove that the treatment plans submitted are reasonable and necessary. I reject that contention, because:

[3] 16-000575/AABS, February 2, 2017.

i. I am subject to the provisions of the Act[4] and the *Schedule* and I can find no authority for me to relieve the respondent from its liability under s.38 (11) on the basis that the disputed assessment plan isn't reasonable and necessary.[5]

ii. Accepting the respondent's position would render s. 38(11) of the *Schedule* practically ineffective.[6]

[19] In this case, the applicant received two EOBs. The initial EOB was dated February 25, 2016 and the second was dated July 29, 2016. The second EOB was issued subsequent to two IEs -- physiatry and psychological -- both conducted on July 27, 2016.

Initial EOB

[20] The applicant argues that when the respondent denied her claim for a CPA they did not comply with s. 38 of the *Schedule*. In support of this argument the applicant submits that:

i. The initial EOB of the disputed CPA plan failed to include reasons for the insurer's refusal to pay the claim, included no supporting reports and furthermore omitted any details of how the claim was evaluated or by whom.

ii. The second EOB was based on a psychological IE which provides medical opinions on issues that the applicant argues are irrelevant to the CPA she seeks – and therefore effectively denies her the right to challenge the insurer's refusal to pay.

iii. The respondent failed to provide the required copy of its IE reports and associated EOB within the ten business days prescribed by s.38(13,14) of the *Schedule,* which she argues entitles her to payment of the disputed benefit.

[21] The applicant argues that the above-noted non-compliance is not merely technical, but in fact is material and denies her right to a fair understanding of the reasons for denial and to the information she needs to decide whether or not to challenge the denial.

[22] I find the decision in *Klimitz and Allstate Insurance Company of Canada*[7] submitted by the applicant to be instructive and persuasive in setting the standard for EOB disclosure in this matter:

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[4] *Insurance Act*, RSO 1990, c.I.8.
[5] I concur with the decision in *Lin and State Farm Mutual Auto Insurance Company,* (FSCO A12-007465, June 23, 2015) which makes this point.
[6] The same finding was made in *Ferawana and State Farm Mutual Auto Insurance Company* (FSCO A13-005319, August 29, 2016).

i. The reasons given by the insurer must be sufficient to permit the insured person to decide whether or not to challenge its refusal to pay for claimed benefits.

ii. The inherently intrusive nature of requiring an IE requires the *quid pro quo* of permitting the applicant the chance to review and question the resulting IE report.

[23] The initial EOB tells the applicant that payment for the disputed CPA plan dated February 5, 2016 has been refused and goes on to inform her that it will be conducting an "Insurer Examination with respect to these goods and services with details to be provided at a later (unspecified) date". An addendum states that "based on medical documents received to date", the applicant's "injuries appear to fall within the minor injury limit" and that "this OCF 18 is denied as it exceed [*sic*] the minor injury limit." The initial EOB was send on February 25, two days after the applicant submitted her claim for the disputed CPA.

[24] The respondent argues that this denial was based explicitly on the medical information available at that time and that it would be unreasonable to expect a more detailed EOB because at that time it had only limited medical evidence on which to make a determination. The EOB stated in effect that it did not find the applicant's medical documentation sufficient to remove her from the MIG and denied her claim on that basis.

[25] I find that the respondent's initial denial was compliant with s.38 of the *Schedule*. I reached this conclusion because:

i. The *Schedule* does not require the detailed information suggested by the applicant, namely "supporting reports" and an explanation of how conclusions were reached.

ii. I do not find it plausible that the *Schedule* can be interpreted to require the insurer to provide more information than it has at the time of denial.

iii. I am guided by the reasoning set out at page 10 of *Augustin and Unifund Insurance Company*, in which the adjudicator distinguished between a "medical reason" and the more detailed analysis involved in medical opinions – with the former being acceptable in an EOB.[8]

iv. My own reading of the initial EOB is that it provided the applicant with a basis on which to challenge it, because it indicated that she was considered to be covered by the Minor Injury Guideline, which she could challenge by contending

[7] (FSCO Appeal, P12 00026, March 13, 2013).
[8] *Augustin and Unifund Insurance Company*, (FSCO A12 – 000452, November 13, 2013).

that the CPA plan itself and other medical information she provided placed her outside the guideline and established that a CPA is reasonable and necessary.

v. The EOB includes notice of the respondent's intention to conduct IEs, as prescribed by s.38(10) of the *Schedule*.

Second EOB

[26] The respondent's second EOB of July 29, 2016 states in Part 4 of the form that:

i. The applicant's claim for a chronic pain assessment is denied based on a psychological IE conducted July 27, 2016;

ii. The applicant is removed from the MIG on the basis of a physiatry IE conducted July 27, 2016.

[27] The second EOB provides more detailed information, naturally, than the first, setting out the opinions of each IE practitioner and relating them to the determinations made by the respondent.

[28] The second denial also includes both IE reports. The respondent submitted evidence in the form of a fax transmittal certificate dated August 2, 2016 to prove its compliance with s.38(13) of the *Schedule*. The certificate is uncontroverted by the applicant and I therefore find the question of notice in favour of the respondent.

[29] The applicant argues that the psychological report upon which the respondent relied in its denial was irrelevant to the issue of chronic pain and that as a result it provided no basis on which the applicant could challenge the denial.

[30] I find the applicant's argument unpersuasive with respect to the sufficiency of denial and compliance with s.38. I find nothing about the psychological report or the respondent's reliance on it that impedes the applicant from challenging the denial and meeting the onus on her to show that a claimed benefit is reasonable and necessary.

[31] I find that the second EOB was compliant with s.38 of the *Schedule*.

[32] I will consider the applicant's arguments on this point in determining the merits of its appeal. However, the applicant's request that I set aside the respondent's EOBs and denials and order payment of the disputed medical benefit is denied.

Is the Chronic Pain Assessment Reasonable & Necessary?

[33] Section 14 and 15 of the *Schedule* provide that an insurer is only liable to pay for medical expenses that are reasonable and necessary as a result of the accident.

The applicant bears the onus of proving on a balance of probabilities that each treatment and assessment plan is reasonable and necessary.[9]

[34] The applicant relies on her series of treatment and assessment plans as evidence of the "ongoing nature" of her injuries and "persistent pain even after treatment" that indicate "at least that she should have the opportunity to be assessed by a chronic pain specialist". No other evidence is submitted with respect to chronic pain.

[35] The applicant points to the weakness of the respondent's IEs in not addressing directly the issue of chronic pain. She argues that the respondent did not properly address the contents of the disputed CPA plan and did not adequately account for the other plans, even though it ultimately approved them – she asks me to consider those approvals as evidence of the applicant's need for an assessment.

[36] The respondent argues that the applicant has not met her onus to prove that the disputed assessment plan is reasonable and necessary. In support of its position, it offers evidence to rebut the applicant's position that she suffers from persistent and intractable pain that warrants a full chronic pain assessment. This evidence includes:

i. The applicant's statements to IE examiners, Dr. Lawrence Tuff, psychologist, and Dr. Ryan Williams, physiatrist, on July 27, 2016, that:

   a) she plays elite soccer 5-6 times per week – more often than she did before the accident, earning extra gym credit at school for her play;

   b) she missed no school (with the exception of gym class for 5 months in 2014-15 school year) as the result of the accident and continues to earn excellent academic grades;

   c) her pain "was not nearly as bad as it was" and that it was "75% improved";

   d) lower back pain was intermittent, associated with prolonged sitting and relieved by physiotherapy, stretching and activity such as playing soccer.

ii. The applicant's apparent failure to pursue treatment under a number of approved treatment plans since being removed from the MIG, including a recent treatment plan from Dr. Christopher Sly, dated February 22, 2017, for chiropractic treatments.

iii. Medical documents indicating that the applicant's pain symptoms have steadily abated since the accident:

[9] *Scarlett v. Belair,* 2015 ONSC 3635.

a) a letter from Dr. Azer, the applicant's family physician, noting improvement (dated September 22, 2015);

b) a report from Dr. Kramarchuk, a physiatrist to whom the applicant was referred for assessment, who noted 85-90% normal range of movement and recommended physiotherapy, independent exercise and other modalities with no reference to chronic pain;

c) clinical notes and records from Prime Health, one of the applicant's treatment providers, dated August 25 to December 23, 2014, noting steadily decreasing pain and increasing range of motion;

d) a letter from Dr. Sly, the applicant's treating chiropractor, dated June 6, 2016, recommending chiropractic treatment but with no commentary on chronic pain.

[37] I find that, on balance, the evidence against the need for a chronic pain assessment outweighs the applicant's evidence. My reasons for this conclusion are:

i. The documents cited by the respondent indicate a steady improvement in the applicant's pain symptoms and range of motion, an activity level consistent with pre-accident activities, and a failure to pursue treatment approved by the respondent – all unaddressed by the applicant -- which I find undermine the case for a chronic pain assessment.

ii. I assign great weight to the applicant's own reporting of her return to normal activities and reduced pain – both of which are listed as goals in the various plans submitted in evidence by the applicant.

iii. In reading the approved treatment plans submitted as evidence by the applicant, there was no basis for drawing any inferences of a "building case" for a chronic pain assessment and certainly none that would outweigh the contradictory evidence adduced by the respondent.

[38] I find that the applicant has failed to meet the onus on her to prove that the disputed CPA is reasonable and necessary.

Request for Interest

[39] Section 51 of the *Schedule* sets out the criteria for assessing and awarding interest on overdue payments.

[40] In this case, the applicant is not entitled to interest on denied claims, because no payment is due from the insurer.

Costs

[41] Rule 19.1[10] permits a party to request that the Tribunal order the other party to pay costs, where the requesting party "believes that another party in a proceeding has acted unreasonably, frivolously, vexatiously, or in bad faith".

[42] There is no basis on which to award costs in this matter.

CONCLUSIONS

[52] The respondent's EOBs complied with the requirements of s.38 of the *Schedule*.

[53] The applicant has not proven her entitlement to a medical benefit for a chronic pain assessment.

[54] No payments are overdue and therefore, no interest is payable.

[55] There is no basis for a cost award. The applicant's request is denied.

Released: November 7, 2017

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Christopher A. Ferguson, Adjudicator

[10] *Licence Appeal Tribunal Rules of Practice and Procedure, Version I (April 1, 2016).*