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

Tribunal File Number: 18-011638/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:

D.M.

Applicant

and

Allstate Insurance

Respondent

DECISION

PANEL: **Jesse A. Boyce, Adjudicator**

APPEARANCES:

For the Applicant: Paul J. Cahill

For the Respondent: Heather Kawaguchi

HEARD: **In Writing on: January 29, 2020**

OVERVIEW

[1] D.M. was injured in an automobile accident on August 16, 2014 and sought various medical and attendant care benefits from the respondent, Allstate, pursuant to the *Statutory Accident Benefits Schedule – Effective September 1, 2010*[1] (the "*Schedule*").

[2] D.M.'s medical history is notable for recurring injuries resulting from three separate automobile accidents in 1982, 2000 and 2008, as well as a workplace accident from 1978. As a result of the subject accident here, D.M. alleges he suffers from pain, specifically in his back, neck and shoulders, headaches, tinnitus, post-concussion syndrome, small fibre neuropathy in his feet, chronic pain, sleep disturbances and psychological impairments.

[3] D.M. applied for attendant care benefits ("ACBs") and several other medical benefits. Allstate denied ACBs on the basis that D.M. did not submit his claim properly or in a timely manner, that he was not entitled to attendant care because he is not catastrophically impaired, and that he did not incur or provide evidence that he incurred the care he claims. Allstate denied the medical benefits and costs of examination on the basis that that they were duplicative and not reasonable and necessary. D.M. disagreed and applied to the Licence Appeal Tribunal – Automobile Accident Benefits Service (Tribunal) for resolution of the dispute.

ISSUES TO BE DECIDED

[4] The following are the issues to be decided, as set out in the case conference order dated May 10, 2019:

(i) Is the applicant entitled to receive attendant care benefits in the amount of $887.06 per month for the period October 31, 2017 to date and ongoing?

(ii) Is the applicant entitled to a medical and rehabilitation benefit in the amount of $1,842.21 for psychological treatment recommended by York Region Psychological Services in a treatment plan (OCF-18) submitted on April 26, 2017 and denied on May 11, 2017?

(iii) Is the applicant entitled to a medical and rehabilitation benefit in the amount of $1,640.00 for chiropractic treatment recommended by Dr. R.

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[1] O. Reg. 34/10.

Turner in a treatment plan (OCF-18) submitted on April 14, 2017 and denied on August 18, 2017?

(iv) Is the applicant entitled to a medical and rehabilitation benefit in the amount of $2,460.00 for a physiatry assessment recommended by Rehab First Inc. in a treatment plan (OCF-18) submitted on September 12, 2017 and denied on September 26, 2017?

(v) Is the applicant entitled to a medical and rehabilitation benefit in the amount of $2,460 for review of documents in the course of the physiatry assessment submitted on September 12, 2017 and denied on September 25, 2017?

(vi) Is the applicant entitled to a medical and rehabilitation benefit in the amount of $2,460.00 for a neurological assessment recommended by Rehab First Inc. in a treatment plan (OCF-18) submitted on September 12, 2017 and denied on September 26, 2017?

(vii) Is the applicant entitled to a medical and rehabilitation benefit in the amount of $2,460.00 for a functional abilities assessment recommended by Rehab First Inc. in a treatment plan (OCF-18) submitted on September 12, 2017 and denied on September 26, 2017?

(viii) Is the applicant entitled to a medical and rehabilitation benefit in the amount of $2,460.00 for a neurological assessment recommended by Rehab First Inc. in a treatment plan (OCF-18) submitted on August 25, 2017 and denied on September 26, 2017?

(ix) Is the applicant entitled to a medical and rehabilitation benefit in the amount of $2,764.15 for occupational therapy recommended by Rehab First Inc. in a treatment plan (OCF-18) submitted on October 16, 2017 and denied on September 26, 2017?

(x) Is the applicant entitled to interest on any overdue payment of benefits?

[5] Following receipt of D.M.'s submissions, the Tribunal received correspondence from D.M., dated June 26, 2019, indicating that the parties were able to resolve issue ix, as well as certain issues listed in the application but not identified in the Case Conference Order.

RESULT

[6] I find on the evidence that D.M. is not entitled to ACBs as he is not catastrophically impaired, did not make his claim for the benefits within the statutory timeline, and has not demonstrated that attendant care was incurred.

[7] I find that D.M. is not entitled to payment for any of the costs of examinations as they are duplicative and not reasonable and necessary.

[8] I find that D.M. is not entitled to payment for any of the medical and rehabilitation benefits in dispute as they are not reasonable and necessary.

ANALYSIS

Attendant Care Benefits

[9] I find that D.M. is not entitled to ACBs as he has not demonstrated that he is catastrophically impaired, he did not make his claim for the benefits within the statutory timeline, and has not demonstrated that attendant care was incurred.

[10] Section 42(1) of the *Schedule* states that an application for ACBs must be in the form of, and contain the information required to be provided in, the version of the document entitled Assessment of Attendant Care Needs ("Form-1") approved by the Superintendent for use in connection with the claim, as well as be prepared and submitted to the insurer by an occupational therapist or a registered nurse. Section 19 of the *Schedule* states that an insurer shall pay for all reasonable and necessary expenses incurred by or on behalf of an insured person as a result of an accident for services provided by an aide or attendant.

[11] Section 3(7)(e) provides guidance on when an expense is incurred: (i) the insured person has received the goods or services to which the expense relates, (ii) the insured person has paid the expense, has promised to pay the expense or is otherwise legally obligated to pay the expense, and (iii) the person who provided the goods or services, (A) did so in the course of the employment, occupation or profession in which he or she would ordinarily have been engaged, but for the accident, or (B) sustained an economic loss as a result of providing the goods or services to the insured person.

[12] D.M. submits that he was assessed by Allstate as requiring $887.06 per month in attendant care but has been denied the benefit because he is not catastrophically impaired, despite having significant functional impairments. In addition, he argues that the *Schedule* in effect on the date of loss does not

require that he be catastrophically impaired. D.M. states that he is disabled from engaging in housekeeping and home maintenance activities.

[13] In response, Allstate offers several compelling arguments. First, Allstate submits that attendant care is not payable before receipt of a Form-1 or, pursuant to s. 20(2) of the *Schedule*, where an application is received more than 104 weeks after an accident and the applicant is not catastrophically impaired. Second, it argues that the evidence before the Tribunal does not support entitlement to attendant care. Third, and in any event, Aviva maintains that D.M. has not proven that he incurred any attendant care, as defined by s. 3(7)(e).

[14] I agree with Allstate. The Form 1 submitted on October 31, 2017 was done in accordance with an approved OCF-18 and was not an insurer's examination nor was it done by a medical professional hired by Allstate, as D.M. suggests. Rather, the Form 1 was submitted on behalf of D.M. On review of the two Explanations of Benefits concerning attendant care, Allstate acknowledged the Form 1 but advised D.M. that in accordance with ss. 20(2) and (3) of the *Schedule*, no attendant care benefit is payable for expenses incurred more than 104 weeks after the accident unless the insured person sustains a catastrophic impairment as a result of the accident. The letters explain that, since D.M. does not suffer from a catastrophic impairment, no attendant care was payable beyond August 16, 2016, being the 104-week mark from the accident. I agree with Allstate that it was clearly indicating that because D.M. was not catastrophically impaired, s. 20(3) did not apply to extend the duration of availability of attendant care benefits, so none is payable.

[15] Further, I find there is no evidence that D.M. has submitted an OCF-19 or that he has been deemed catastrophically impaired. Accordingly, I see no basis to deviate from Allstate's position that because D.M.'s claim for attendant care was submitted beyond the period of entitlement, it is statute-barred by ss. 20(2) and (3) because there is no possibility of entitlement after August 16, 2016 in the absence of a catastrophic determination, since there is no basis for extending the duration of availability.

[16] Perhaps more fatal to D.M.'s claim than the above is the requirement that in order to receive payment for attendant care in accordance with s. 20(2) of the *Schedule,* attendant care benefits must be an "incurred" expense, as defined by s. 3(7)(e) and outlined above. In parsing through D.M.'s evidence, I echo Allstate's submission that there were no attendant care invoices submitted, no service providers identified, and no evidence to support or suggest that D.M. has incurred any amounts for attendant care since the accident. Simply put,

nothing has been advanced to support or prove that the amounts claimed, or any amounts, have been incurred, pursuant to s. 3(7)(e). As no attendant care has been incurred, it follows that none is payable.

[17] As a result, I find that D.M. is not entitled to payment for attendant care.

Are the costs of examinations reasonable and necessary?

[18] I find that D.M. is not entitled to any of the costs of examinations as they are duplicative, excessive and not reasonable and necessary.

Physiatry Assessment (iv and v)

[19] D.M. seeks payment for two Physiatry Assessments in an amount totalling $4,920.00. The Case Conference Order lists the assessment as two separate issues, but it appears that the total amount was split in half and two OCF-18s in the amount of $2,460.00, both dated September 12, 2017, were submitted by the same assessor. D.M. argues that the assessments are reasonable and necessary due to his chronic pain and pre-existing conditions that were exacerbated by the subject accident.

[20] In response, Allstate submits that the two OCF-18s are simply different components to one physiatry assessment, pointing out that one OCF-18 amount is for a telephone interview and the second OCF-18 is for reviewing documents and writing the report, with both to be conducted by the same assessor. Allstate submits that this is an attempt to circumvent s. 25(5)(a) of the *Schedule*, which sets out a $2,000.00 cap in respect of fees and expenses for conducting any one assessment or examination and for preparing reports in connection with it. As such, it argues the amounts claimed are not reasonable or necessary as the OCF-18s are in breach of s. 25. Further and in spite of the above, Allstate's denial letter dated November 6, 2017 provided a copy of the Paper Review by Dr. Jugnundan which found that, based on the notes of the family doctor and given that D.M. already had an independent orthopedic assessment and a neurological assessment, the need for a physiatry assessment was not reasonable and necessary. Allstate submits that the amount is excessive and the OCF-18s are a duplication and therefore should not be found payable.

[21] I agree. It is well-settled that it is the applicant's burden to prove that treatment plans are reasonable and necessary and incurred in order to receive payment from the insurer. Other than listing his impairments and pain, D.M. does not explain why the physiatry assessments are reasonable and necessary. The OCF-18's do not provide compelling evidence that a physiatry assessment at

the cost claimed is reasonable and necessary. The additional comments section only provides that the assessment and report is required to assess D.M.'s physical injuries from the accident and that, without the assessment, D.M. may be at an increased risk of persistent or worsening of his symptoms. To be frank, I find D.M.'s accident-related impairments—as well as his lengthy pre-existing impairments—to be well-documented throughout the file. I query why a two-pronged OCF-18 is required at this cost simply to re-state D.M.'s injuries which can be found in several other places and are reported with relative consistency by D.M. Further, it was not explained why this particular physiatry report will somehow prevent D.M. from an increased risk or worsening of his symptoms where many of his symptoms have been present for years, if not decades. For these reasons, I do not find that any physiatry assessment is reasonable or necessary.

[22] Further, I agree with Allstate that the bifurcation of the assessment into two separate OCF-18s—and therefore two separate payments—is concerning. The OCF-18s are largely identical, are completed by the same two practitioners and do not speak to the need or justification for these separate reports and expenses, both of which are claimed at the top of the Guideline rate. In my view, when the questionable decision to split the assessment into two parts is considered, I cannot help but agree with Allstate that it is a clear attempt to circumvent s. 25(5)(a) of the *Schedule* which sets out a $2,000.00 cap. Accordingly, I find no reason to interfere with Allstate's determination that it is not reasonable and necessary.

Neurological Assessment (vi and viii)

[23] D.M.'s request for a neurological assessment and report is similar to his claim for the physiatry report. Here, D.M. seeks the cost of a neurological assessment in the amount of $4,920.00. Again, it appears that this claim is really only one assessment that was submitted via two treatment plans with the total cost split between the OCF-18s. Both treatment plans are again dated August 25, 2017 and both are for $2,460.00. It appears that this is one assessment divided into a document review portion and an assessment portion, both to be conducted by the same assessor.

[24] D.M. argues that the assessment is reasonable and necessary in order to address the numbness in his feet and his chronic pain. As this is really only one report, Allstate submits that it is not reasonable or necessary and the amount is excessive and not payable in accordance with the *Schedule* as, much like the physiatry assessment above, it is a duplication of services. Further, Allstate

advised D.M. that the assessment was not reasonable and necessary, relying on the Paper Review of Dr. Jugnundan as well as the fact that D.M. had already been thoroughly assessed.

[25] Again, I agree with Allstate. D.M. was seen by neurologist Dr. Bril at the recommendation of another neurologist, Dr. Baryshink, on March 15 and June 28, 2016. Dr. Bril made findings and did not recommend that any further neurological investigation was necessary. I agree with Allstate that any further neurology assessment would be a duplication of these previous assessments and that the reasonableness and necessity for further assessments is not explained by D.M. or by the OCF-18's. Against these facts, I also reiterate that the bifurcation of the assessment into two separate OCF-18s—and therefore two separate payments—remains concerning. The OCF-18s for the neurological assessment are, again, largely identical, are completed by the same two practitioners and do not speak to the need or justification for these separate reports and expenses, both of which are claimed at the top of the Guideline rate.

[26] Further, the OCF-18s identify the same purpose with the same authors and the same testing. I cannot help but agree with Allstate that it is another attempt to circumvent s. 25(5)(a) of the *Schedule* which sets out a $2,000.00 cap. Accordingly, on this basis and given that other neurologists have determined that no further neurological investigation is required, I find no reason to interfere with Allstate's determination that it is not reasonable and necessary.

<u>Functional Abilities Evaluation (vii)</u>

[27] D.M. seeks the cost of a Functional Abilities Evaluation ("FAE") in the amount of $2,460.00 from an OCF-18 dated August 24, 2017, that was submitted by his speech language pathologist. The treatment plan was submitted by Rehab First, Inc. in the same batch as the Physiatry and Neurological Assessment OCF-18s.

[28] D.M. argues that the FAE is reasonable and necessary due to the fact that he has been continuously prevented from engaging in substantially all of his pre-accident activities at home and in his employment. In response, Allstate offers several arguments: first, it submits that a FAE is not an appropriate measure to determine entitlement to benefits since no income replacement benefits or housekeeping were payable; second, Allstate denied payment of the FAE in accordance with the Paper Review by Dr. Jugnundan for the same reasons as the other assessments and that a speech language pathologist is not qualified, nor the appropriate assessor, to recommend a FAE which makes the reasonableness suspect; and, third, that D.M. submitted an OCF-18 dated

September 12, 2017 for a rehabilitation needs assessment which was approved and therefore a FAE is a duplication.

[29] I agree. It is unclear why D.M. was claiming a FAE when he was not seeking income replacements and, in any event, it was found that he did not meet the test for same. Further, D.M. was approved for a rehabilitation needs assessment shortly after submitting the FAE OCF-18. The additional comments section of the OCF-18 does not speak to the services necessary for this assessment or why it is needed above and beyond a rehabilitation needs assessment. The goal of the assessment seems to be similar to the one identified in the physiatry and neurology OCF-18s: to determine D.M.'s current functional status and that, without this assessment, D.M. "is at risk of continued difficulty fulfilling his work responsibilities and providing for his family." To be frank, D.M.'s functional impairments are littered throughout the file and, to his credit, his limitations appear to be quite clear to him in his self-reporting. In my view, and considering D.M. was undergoing treatment when this plan was submitted, it remains unclear why a separate FAE was reasonable and necessary. As D.M. did not provide submissions speaking to this, I see no reason to interfere with Allstate's determination that the FAE was not reasonable and necessary.

[30] Accordingly, I find D.M. is not entitled to payment for any of the costs of examinations in dispute.

Are the treatment plans in dispute reasonable and necessary?

<u>$1,640.00 for Chiropractic Treatment</u>

[31] D.M. seeks payment for chiropractic treatment in the amount of $1,640.00, submitted via OCF-18 on April 14, 2017. D.M. argues that the treatment is reasonable and necessary to help ease his lingering pain because he suffers from severe, objective injuries requiring ongoing treatment.

[32] Allstate submits that it notified D.M. on August 18, 2017 that all OCF-23s, OCF-18s and OCF-21s were to be submitted exclusively through the HCAI website and that this OCF-18 was not submitted through HCAI and, therefore, was not able to be considered. Further, Allstate argues that D.M. has failed to submit this OCF-18 via HCAI and there is no evidence of an attempt to do so. As it is D.M.'s burden to prove his claim and advance evidence to show that this treatment plan was submitted via HCAI, Allstate cannot provide evidence of something that D.M. has failed to do.

[33] On review of the documentation before the Tribunal, it does not appear that the OCF-18 in question is in evidence, which provides support for Allstate's claim, as the Explanation of Benefits advising D.M. of the HCAI requirement is before the Tribunal. In any event, D.M. does not advance any specific submissions detailing why chiropractic treatment—and this treatment plan specifically—is reasonable and necessary. Allstate also submits that, in the 10 months before the accident, D.M. was receiving regular chiropractic treatments and his subjective self-reports of improvement fluctuate during this period. While I accept that D.M. has pain and that pain reduction is a legitimate goal of treatment, in the absence of something more supportive of entitlement, I follow Allstate's determination that D.M. has not satisfied his burden to prove that the treatment is reasonable and necessary.

$1,842.21 for Psychological Treatment (ii)

[34] D.M. seeks payment for a medical and rehabilitation benefit in the amount of $1,842.21 for psychological treatment. The dispute is over an OCF-18 dated April 26, 2017. D.M. argues it is reasonable and necessary to treat his accident-related psychological impairments.

[35] On the evidence, it appears that D.M. was approved for a larger slate of psychological treatment as a result of an OCF-18 dated May 9, 2017, which was submitted shortly after this treatment plan. Allstate conducted an Insurer's Examination with Dr. McKay to determine whether psychological treatment was reasonable and necessary. The report determined that D.M.'s impairments required exploration by a professional and diagnosed him with Adjustment disorder with mixed anxiety and depressed mood. The report approved the larger and more expensive amount of treatment and denied this plan, which featured less treatment, was cheaper and older in time.

[36] In submissions, D.M. does not address why this particular treatment is reasonable and necessary in the face of the larger, approved block of treatment that came two weeks later. Further, while it is apparent that D.M. has been attending for psychological treatment, and I am alive to Dr. McKay's diagnoses and D.M.'s self-reporting, he does not address why this particular treatment plan would be beneficial to his maximal recovery or how his previous treatment benefitted him in order to justify the reasonableness and necessity of continuing treatment.

[37] For these reasons, I find that D.M. is not entitled to payment for the psychological treatment plan as it is not reasonable and necessary.

$3,392.24 for an Orthopedic Mattress

[38] Finally, although it was not captured by the Case Conference Order, the parties agree that D.M. is also seeking payment for an orthopedic mattress in the amount of $3,392.24, via an OCF-18 dated December 6, 2017. The cost breakdown of this issue is as follows: $200.00 for medical/rehabilitation documentation, $2,749.99 for the ergonomic mattress, $75.00 for shipping fees and $367.25 in tax.

[39] D.M. describes ongoing sleep disturbances throughout the file as evidence that the mattress is reasonable and necessary. In addition to ongoing accident-related symptoms of head pressure, pain, tension, and neuropathy, D.M. claims to have been diagnosed with sleep apnea and is required to sleep with a mask, which further attributes to discomfort and sleep disturbance. D.M. argues that the mattress would assist him in returning to his pre-accident activities. In response, Allstate relies on the report of occupational therapist, Ms. Zelek, who found no objective information to warrant the medical need for the proposed ergonomic mattress and associated services. Allstate contends that D.M. has not identified any medical reasons why the mattress is reasonable or necessary to address sleep problems that existed prior to the motor vehicle accident.

[40] While I do not find the cost of the mattress to be excessive, I agree that there is limited evidence provided by D.M. linking his accident-related impairments to the need for an ergonomic mattress and a dearth of submissions on same. Indeed, it appears that D.M.'s complaints of sleep disturbances began before the accident, in 2013 at the earliest. On this basis, I find that D.M. has not demonstrated why the mattress will specifically reduce or eliminate the effects of his impairments or help facilitate his reintegration into his home or work life and question the connection to the subject accident. I find the mattress is not reasonable and necessary.

Interest

[41] As no benefits are overdue, no interest is payable under s. 51 of the *Schedule*.

CONCLUSION

[42] I find D.M. is not entitled to ACBs as he is not catastrophically impaired, did not make his claim for the benefits within the statutory timeline and has not demonstrated that attendant care was incurred. D.M. is not entitled to payment for any of the costs of examinations or the medical benefits as they are not reasonable and necessary.

Released: February 20, 2020

Jesse A. Boyce
Adjudicator