Citation: Hastings vs. Royal Sun Alliance Insurance, 2021 ONLAT 20-001485/AABS

Released: January 22, 2021
Tribunal File Number: 20-001485/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:

Craig Hastings

Applicant

and

Royal Sun Alliance Insurance

Respondent

DECISION

ADJUDICATOR: **Craig Mazerolle, Adjudicator**

APPEARANCES:

For the Applicant: **Kiro Soliman, Paralegal**

For the Respondent: **Geoffrey Keating, Counsel**

HEARD IN WRITING: **November 16, 2020**

OVERVIEW

[1] The applicant was injured in a motor vehicle accident on October 12, 2016. He sought benefits pursuant to the *Statutory Accident Benefits Schedule – Effective September 1, 2010*[1] (the "*Schedule*").

[2] For the reasons to follow, I find the applicant is not entitled to payment for the two disputed treatment plans.

ISSUES

[3] The applicant is requesting medical benefits to fund the following services from Whitby Physiotherapy and Rehabilitation Clinic:

(1) Chiropractic services in the amount of $2,089.71; and

(2) Physiotherapy in the amount of $2,869.66.

[4] The applicant is also requesting interest, an award, and costs.

MEDICAL BENEFITS

[5] Entitlement to medical benefits is determined under ss. 14 and 15 of the *Schedule*. Briefly, the applicant has the onus of demonstrating—on a balance of probabilities—that the services listed in a treatment plan are reasonable and necessary as a result of impairments caused by the accident.

[6] The chiropractic services treatment plan seeks to achieve pain reduction, increased range of motion/strength, and a return to the applicant's pre-accident activity levels. To accomplish these goals, the clinic will use a series of different physical therapy modalities, including massage, stretching, and manipulation.

[7] The physiotherapy treatment plan shares the same treatment goals, and the physical modalities are largely the same (though this treatment plan proposes more sessions of massage therapy than the chiropractic plan).

Parties' Positions

[8] The applicant argued that the accident left him with pain in his upper body. Therefore, both of these physical therapy treatment plans are reasonable and necessary, as they aim to address his accident-related, physical injuries.

[1] O. Reg. 34/10.

[9] The applicant also alleged that both treatment plans were not denied within the ten-day timeline required by s. 38(8) of the *Schedule*, a pattern of non-compliance evidenced by prior cases between these parties (e.g., *17-001315 v. Royal Sun Alliance Insurance*).[2] Additionally, the applicant argued that the respondent relied on an outdated insurer's examination to deny the physiotherapy treatment plan, as this examination took place before the applicant was removed from the *Minor Injury Guideline* (the "MIG").

[10] The respondent challenged the applicant's position by submitting that he has not met his evidentiary burden because he has provided little in the way of medical records. Specifically, an applicant has the onus of establishing entitlement to medical benefits, and the mere production of the disputed treatment plans is not sufficient to meet this burden. Further, both treatment plans seek to address a left shoulder injury that is not accident-related (i.e., he fractured his shoulder during a fall that took place about a month after the subject accident).

[11] The respondent then argued that, while the applicant wants to rely on previous decisions between the parties as evidence of the respondent's past non-compliance, *RSA Insurance* involved a denial of a similar treatment plan to the two now in dispute. No further medical evidence has been provided since this earlier matter was decided, so the Tribunal should be held to this previous denial based on the doctrine of *res judicata*.

Non-Compliance with Section 38(8)

[12] If an insurer wants to deny a benefit, s. 38(8) of the *Schedule* requires them to provide the following information within ten business days of receiving said request:

> Within 10 business days after it receives the treatment and assessment plan, the insurer shall give the insured person a notice that identifies the goods, services, assessments and examinations described in the treatment and assessment plan that the insurer agrees to pay for, any the insurer does not agree to pay for and the medical reasons and all of the other reasons why the insurer considers any goods, services, assessments and examinations, or the proposed costs of them, not to be reasonable and necessary.

[2] 2017 CanLII 99140 (ON LAT) ("*RSA Insurance*").

[13] As noted above, the applicant contended that, not only were both denials out of date, but that the respondent did not provide any medical reasons when it denied the physiotherapy plan.

[14] The respondent denied that its denials were filed outside of the ten-day window, and I accept this submission. The chiropractic services plan was submitted on November 25, 2019, and the letter denying this benefit was dated December 4, 2019—less than ten business days apart. Same for the physiotherapy plan: it was received by the respondent on December 20, 2019, and then denied in a letter dated January 6, 2020 (i.e., within ten business days, when considering statutory holidays). These same denial dates were also mentioned in the applicant's submissions.

[15] The applicant also contended that the respondent sent the denial letters to his former legal representative, such that it cannot be considered proper service. I do not accept this argument, as both letters were copied to the applicant himself.

[16] Then, in regard to the allegedly deficient medical reasons, I do not accept this submission. Briefly, the respondent provided the following reason for denying the physiotherapy treatment plan:

> As per Section 44 Insurer Examination report from Dr. Ahmad Belfon of HVE Healthcare Assessments dated 2017-05-03 in which you were diagnosed with uncomplicated sprain/strain of the right shoulder, the insurer does not agree to pay for the following services:
>
> […]
>
> An Insurer Examination will not be arranged.

[17] According to the applicant, this reasoning is insufficient, as this denial was based on an examination that was conducted prior to his removal from the MIG. Therefore, it was improper to base the denial on this outdated assessment.

[18] I do not find this submission is properly understood as a challenge under s. 38(8). That is, while the applicant may question whether the respondent's stated reasons are supported by the medical evidence, these submissions are better understood as substantive submissions about whether a medical benefit is reasonable and necessary. Therefore, though the applicant may disagree with the respondent's use of this medical report, this stated reliance is a medical reason in accordance with s. 38(8).

[19] Additionally, I do not find the applicant's reliance on *D.S. v. Travelers Insurance*[3] to be helpful. Beyond the fact that the applicant did not provide the Tribunal with a complete copy of the decision, the reasoning used by Adjudicator Paluch to overturn the original decision is at odds with this current dispute. That is, the adjudicator did not find the contested "reasons" to be sufficient for a valid denial, because he concluded that they did not refer to the applicant's medical condition.

[20] I do not have the same concerns about the present reasons provided by the respondent, as the respondent's denial clearly referenced a piece of medical evidence and that is connected to an element of the applicant's accident-related condition (i.e., Dr. Belfon diagnosed the applicant with an "uncomplicated sprain/strain of the right shoulder", and this diagnosis was used to justify the denial).

[21] Though the applicant's submissions limits his argument about the insufficiency of medical reasons to the denial of the physiotherapy plan, I would add that I would reach this same conclusion about the reasons used to deny the chiropractic services plan (as the same medical reasons are cited in both denial letters).

Reasonable and Necessary

[22] I do not find the applicant has met his evidentiary burden to establish entitlement to the disputed medical benefits.

[23] It is trite law that an applicant bears the onus of demonstrating entitlement to a medical benefit. Though the *Schedule* must be interpreted in a manner that is in line with its consumer protection mandate, this mandate does not remove the need for an applicant to establish entitlement to a particular benefit in dispute.

[24] In the present matter, I have been provided with virtually no medical evidence from the applicant. Aside from the cover page of his OCF-1 (which includes a brief, subjective retelling of his accident-related injuries), the only detailed medical account he provided to the Tribunal is found in the disputed treatment plans.

[25] Instead, the applicant appears to be relying heavily on his written submissions, even though it is well-established at the Tribunal that submissions do not constitute evidence. Therefore, without documentary records to support these written arguments, I cannot put any significant weight on these bare assertions.

[3] 2019 CanLII 94018 (ON LAT).

[26] Further, though treatment plans can provide evidence about an applicant's medical condition, I do not find that the two plans in dispute provide a sufficient basis to establish that the requested services are reasonable and necessary.

[27] First, these plans include only sparse details about the applicant's condition, including his reaction to previous physical treatment. For example, aside from subjective reports of "improvements" and a brief reference to the applicant being "able to complete more strengthening", the physiotherapy plan provides no objective test results to help demonstrate the current state of the applicant's accident-related impairments.

[28] Both plans also fail to mention the applicant's post-accident shoulder fracture. I place significant weight on this absence, as much of the functional limitations mentioned in the plans involve the applicant's shoulders: e.g., "Patient is unable to complete many of his housekeeping chores… due to his limited shoulder strength and range of motion." Without accounting for the effects that this fracture may have had on his accident-related impairments (especially the physical impairments involving his upper body), I find it difficult to place much weight on the medical findings in these plans.

[29] In contrast, the respondent provided the Tribunal with the aforementioned report from Dr. Belfon, a report that included both the results of a physical examination and a recognition of his post-accident shoulder fracture. Respondents are not responsible for providing medical records to establish entitlement to disputed benefits, but I cite this report as an example of what kind of information would have provided greater support for the recommendations made in the disputed treatment plans.

[30] I would also note that, while Dr. Belfon did find some issues with the applicant's right shoulder (most notably, a reduced range of motion and some tenderness), this report was produced several years before the disputed treatment plans were filed. As such, without more contemporary and comprehensive medical support for these injuries, I do not find that I have enough compelling evidence to find that physical therapy is still necessary.

[31] Taken together, I am not satisfied that these treatment plans are reasonable and necessary.

AWARD AND COSTS REQUESTS

[32] Section 10 of *Regulation 664* permits the Tribunal to "award a lump sum of up to 50 per cent of the amount to which the person was entitled at the time of the

award" if the Tribunal "finds that an insurer has unreasonably withheld or delayed payments". Rule 19 of the Tribunal's *Common Rules of Practice & Procedure* then states that costs may be awarded where a party has "acted unreasonably, frivolously, vexatiously, or in bad faith" in a proceeding.

[33] The applicant supported his request for an award and costs by submitting that the respondent's non-compliance with the *Schedule* caused "unnecessary delay and deterioration of his condition." The respondent simply denied the claims that it acted in bad faith when adjusting this file.

[34] First, since I have not found either of the treatment plans to be payable, there is no outstanding payments that can form the basis of an award. Further, I have not been provided with any compelling evidence to suggest that the respondent acted in a manner that meets the high standard under Rule 19. Instead, the parties took opposing stances on this dispute, and they acted appropriately at the Tribunal.

ORDER

[35] I find that the applicant has not established that the disputed treatment plans are reasonable and necessary.

[36] There is to be no award or costs order.

Released: January 22, 2021

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Craig Mazerolle
Adjudicator