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: M.G. vs. Aviva Insurance Company of Canada, 2019 ONLAT 18-001568/AABS

Date: July 9, 2019
File Number: 18-001568/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:

M.G.

Applicant

and

Aviva Insurance Canada

Respondent

DECISION

PANEL: **Amanda Fricot, Adjudicator**

APPEARANCES:

For the Applicant: Marni Miller, Counsel

For the Respondent: Nathalie Rosenthall, Counsel

HEARD: **In Writing on: November 26, 2018**

OVERVIEW

[1] The applicant was injured in a motor vehicle accident on December 30, 2016 ("the accident") and sought accident benefits pursuant to the *Statutory Accident Benefit Schedule – Effective September 1, 2010,* O. Reg. 34/10 (the "*Schedule*"). An application was made to the Licence Appeal Tribunal – Automobile Accident Benefit Services (the "Tribunal") after some of her claims for treatment and other medical expenses were denied by the respondent.

[2] This matter proceeded to a written hearing.

ISSUES IN DISPUTE

[3] The following preliminary issue, raised in the applicant's Written Submissions, must be determined prior to determining some of the substantive issues:

(i) Did the respondent's denial of the treatment plans in dispute comply with s. 38(8) of the *Schedule*?

[4] The following substantive issues are in dispute:

(i) Is the applicant entitled to a medical benefit in the amount of $6,753.34 for treatment recommended by Healthmax Physio Clinic Oakville ("Healthmax") in a treatment plan dated September 28, 2017[1] and denied on October 30, 2017?

(ii) Is the applicant entitled to a medical benefit in the amount of $970.00 for chiropractic treatment, recommended by Healthmax in a treatment plan dated October 3, 2017[2] and denied on October 30, 2017?

(iii) Is the applicant entitled to a medical expense in the amount of $117.40 submitted on an OCF-6 dated June 18, 2018 and denied on June 30, 2018?

(iv) Is the applicant entitled to a medical expenses in the amount of $535.59 submitted on an OCF-6 dated June 18, 2018 and denied on June 30, 2018?

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

(vi) Is the respondent liable to pay an award under *Ontario Regulation 664* because it unreasonably withheld or delayed payments to the applicant?

[1] Applicant's Documents, Tab A, at pages 1-13, Treatment Plan dated September 28, 2017.
[2] Applicant's Documents, Tab A, at pages 13-24, Treatment Plan dated October 3, 2017.

RESULT

[5] For the reasons that follow, I find that:

(i) The respondent's denial of the treatment plans in dispute complies with s. 38(8) of the *Schedule*.

(ii) The applicant is entitled to a medical benefit for the pool therapy sessions ("pool sessions") that occurred after October 16, 2017, at the hourly rate of $58.15. The applicant is not entitled to receive a medical benefit for any of the other goods and services recommended in the September 28, 2017 treatment plan.

(iii) The applicant is not entitled to a medical benefit for to the chiropractic services recommended in the treatment plan dated October 3, 2017.

(iv) The applicant is entitled to a medical benefit in the amount of $117.40 for prescription expenses.

(v) The applicant is not entitled to a medical benefit in the amount of $535.59.

(vi) The applicant is entitled to interest in accordance with s. 51 of the *Schedule* on any benefits payable under (ii) and (iv) above.

(vii) The applicant is not entitled to an award under *Ontario Regulation 664*.

ANALYSIS

Preliminary Issues

Did the respondent's denial of the treatment plans in dispute comply with s. 38(8) of the Schedule?

[6] For the reasons that follow, I find that the respondent complied with s. 38(8) of the *Schedule.*

[7] The applicant submits that the respondent's denial of the treatment plans in issue did not comply with the requirements set out in s. 38(8) of the *Schedule*, and that the denial did not set out the medical and other reasons that were the basis for the denial. In support of her position the applicant relies on the fact that the respondent based its denial on an Insurer's Examination ("IE") that had addressed a previously submitted treatment plan rather than the treatment plans in dispute.

[8] The applicant submits that as a result of the respondent's breach of s. 38(8) of the *Schedule* she is entitled to payment in accordance with s. 38(11) of the *Schedule.* Section 38(11) of the *Schedule* provides for payment for all services described in the treatment plan and provided in the period starting on the 11th

business day after the day the insurer received the treatment plan and ending on the day the insurer gives a notice that satisfies the requirements set out in s. 38(8) of the *Schedule*.

[9] The respondent does not dispute that in denying the two treatment plans in issue it relied upon the conclusions set out in the IE Report of Dr. Abounaja[3]. That Report had been prepared following a General Practitioner's IE assessment on October 13, 2017, conducted for the purpose of determining whether a prior treatment plan for chiropractic services was reasonable and necessary.

[10] In its October 30, 2017 Explanation of Benefits letter denying the treatment plans, the respondent stated:

> "…we have determined the proposed OCF18's submitted are not reasonable and necessary based on our recent Independent General Practitioner Assessment report dated October 24, 2017. Dr. Mohamed Abounaja indicate[s] on his report that you reached maximum medical recovery, therefore further facility-based treatments is not reasonable and necessary required for the injuries you received in this motor vehicle accident.
>
> Therefore, since we have no new supporting medical documentation for our review and there has been no change in your physical injury/impairment, we are relying on the report completed by Dr. Abounaja to deny the above noted proposed treatment plans."[4]

[11] I find that the respondent complied with its obligation under s. 38(8) of the *Schedule* as it clearly explained the basis for the denial, with reference to the applicant's medical condition and the IE Report. That IE Report was based on an IE assessment conducted on October 13, 2017, within days of when the treatment plans in dispute were submitted. I find that the respondent provided the applicant with the medical and all other reasons for its denial and complied with s. 38(8) of the *Schedule*. The fact that one of the denied treatment plans was ultimately found to be reasonable and necessary does not negate the respondent's compliance with s. 38(8) of the *Schedule,* as the respondent's reasons for its denial clearly indicated why the treatment plans were denied and allowed the applicant to make an informed decision regarding whether she should apply to the Tribunal to dispute the denial.

[12] As I find that the respondent complied with s. 38(8) of the *Schedule,* s. 38(11) of the *Schedule* does not apply.

[3] Respondent's Document Brief, Tab 17, IE Report of Dr. Mohammad Abounaja, dated October 24, 2017.

[4] Applicant's Documents, Tab A, at pages 54-58, Letter from the respondent to the applicant dated, October 30, 2017

Substantive Issues

[13] Sections 14 and 15 of the *Schedule* provide that an insurer is liable to pay for medical benefits for all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of an accident.

[14] The onus is on the applicant to prove, on a balance of probabilities, that the medical benefits sought are reasonable and necessary as a result of the injuries sustained in the accident.[5]

Is the applicant entitled to the medical benefits for the treatment recommended in the September 28, 2017 treatment plan?

[15] The treatment plan dated September 28, 2017 recommends an aqua therapy and rehabilitation program that includes pool sessions, a facility usage fee and acupuncture treatments. As well it recommends a physiotherapy initial assessment, "Hurt vs. Harm" sessions, and a progress report.

[16] For the reasons that follow, I find that the only services recommended in the September 28, 2017 treatment plan that are reasonable and necessary are the pool sessions and that the respondent is liable for the cost of those sessions incurred after the treatment plan was submitted by the applicant. I further find that as the evidence does not establish that the pool therapy was provided by a physiotherapist, the maximum hourly rate allowed for those sessions is $58.15.

Does Section 38(2) of the *Schedule* limit the applicant's entitlement to benefits claimed in the September 28, 2017 treatment plan?

[17] Prior to considering the evidence relating to the reasonableness and necessity of the treatment proposed in the September 28, 2017 treatment plan, I will consider the respondent's submission that it is relieved of some or all of its obligation, if any, to pay for the treatment recommended therein based on s. 38(2) of the *Schedule.* Section 38(2) of the *Schedule* states that an insurer is not liable to pay an expense that is incurred before the insured submits a treatment plan. It was not alleged that the exceptions set out in s. 38(2)(a), (b) or (c) of the *Schedule* apply in this case.

[18] I must first determine when the treatment plan was submitted. The Tribunal's Order dated August 15, 2018 refers to the treatment plan as having been submitted on October 3, 2017. The applicant's Written Submissions[6] state that this treatment plan was "submitted on an OCF 18 dated October 3, 2017 and received on October 16, 2017". The respondent's Written Submissions[7] state that the treatment plan was not received until "on or about October 17, 2017". The

[5] Respondent's Document Brief: Tab 7, *Scarlett v. Belair Insurance Company,* 2015 ONSC 3635 (Div'l Ct); and Tab 6, Owasa v. T. D. Insurance Company, 2010 ONSC 6627 (Div'l Ct.).

[6] Applicant's Written Submissions, dated October 14, 2018 ("Applicant's Submissions"), at paragraph 28.

[7] Respondent's Written Submissions, dated November 5, 2018 ("Respondent's Submissions"), at paragraph 17.

respondent's letter to the applicant dated October 30, 2017[8] states that it was received on October 16, 2017. I find that the treatment plan was submitted on October 16, 2017, the date the evidence indicates that it was received by the respondent. The evidence does not establish the time on October 16, 2017 that the treatment plan was submitted.

[19] The respondent relies on *P.K. v Cumis General Insurance*[9] which found that the applicant was not entitled to expenses incurred prior to a treatment plan being submitted. The applicant made no submissions in her Reply respecting the applicability of s. 38(2) of the *Schedule*.

[20] As the treatment plan was not submitted until October 16, 2017, I find that, in accordance with s. 38(2) of the *Schedule,* the respondent is not liable to pay for treatment that was incurred prior October 17, 2017, even if it is found to be reasonable and necessary.

Is the treatment recommended in the September 28, 2017 treatment plan reasonable and necessary?

[21] The various types of treatment recommended in the September 28, 2017 treatment plan are considered below.

Aqua Therapy and Rehabilitation Program

Aqua Therapy

[22] I find that aqua therapy is a reasonable and necessary treatment modality in the circumstances of this case for the following reasons. I find that the pool sessions that occurred after the treatment plan was submitted on October 16, 2017 are reasonable and necessary, other than with respect to the hourly rate charged for the same, as discussed below.

[23] The applicant complained of ongoing head, neck, shoulder, back and wrist pain from the date of the accident onward[10]. X-rays taken on the day of the accident did not reveal any fractures. The applicant began receiving physiotherapy treatment almost immediately after the accident[11]. Her treatment included massage, electrotherapy, stretches, exercise, heat, cold and chiropractic adjustments[12]. She initially attended 1-2 times per week. By October 2017 she was attending for treatment up to 3 times a week[13].

[8] *Supra*, footnote 4.
[9] Respondent's Document Brief: Tab 11, *P.K. v Cumis General Insurance,* 2017 CanLii 19204 (LAT).
[10] Applicant's Document Brief, Tabs 4 and 9, excerpts from the Clinical Notes and Records of Dr. Malisic.
[11] Applicant's Document Brief, Tab 3 and 6, excerpts from Clinical Notes and Records of Healthmax.
[12] *Supra*, footnote 3 at page 3.
[13] *Ibid.*

[24] Despite a number of diagnostic tests and referral to, and treatment by, a number of specialists, the applicant's complaints of pain to her family doctor and other health care practitioners continued. In late February 2017 the applicant was referred to an orthopaedic surgeon who diagnosed her with right bicipital tendonitis and right wrist tendonitis, and administered steroid injections to her right shoulder[14]. The April 5, 2017 Consultation Report[15] from a neurologist notes that the applicant reported neck pain, radiating to her right arm, with intermittent numbness in her right arm and hand and wrist pain. No evidence of neuropathy or radiopathy was found. In late July 2017 the applicant reported arm, neck, jaw, shoulder, right wrist and low back pain to her chiropractor.[16] In addition to physical injuries, the applicant suffered from depression and anxiety following the accident. In late July 2017 her family doctor notes that he had previously diagnosed the applicant with mild depression and that she had concussion and whiplash pain, which he opined might be fibromyalgia. He recommended continuing with rehabilitation treatment.[17] An IE psychological assessor noted in July 2017 that the applicant "appears to have developed emotional distress and pain symptoms as a result of the subject motor vehicle accident."[18]

[25] The respondent relies on the IE Report of Dr. Abounaja[19], who assessed the applicant on October 13, 2017. He concludes that there is no objective evidence of residual musculoskeletal impairment attributable to the injuries sustained in the accident, that the applicant had reached maximum medical recovery, and that further facility-based treatment is not reasonable or necessary. Dr. Abounaja's conclusions have been given very little weight in determining whether the aqua therapy recommended is reasonable and necessary for the following reasons. Dr. Abounaja notes that the applicant complained of intermittent excruciating neck pain, very significant intermittent low back pain, as well as constant very significant pain in her shoulders, arms, wrists, chest and upper-mid back pain and headaches. Despite these ongoing complaints of accident-related pain, he makes no comment on, or recommendations related to, the applicant's ongoing pain. The reasonableness or necessity of aqua therapy, which was recommended to treat the applicant's ongoing pain, was not a treatment modality that Dr. Abounaja was asked to comment on, nor did he do so in his IE Report.

[26] As the applicant continued to experience pain from the time of the accident onwards, I find that aqua therapy is a reasonable and necessary form of treatment in this case. Although not specifically addressing the aqua therapy recommended, the clinical notes and records of her family doctor and treating health care practitioners, as well as excerpts from the reports of assessors, all confirm the applicant's continuing pain, despite receiving various forms of therapy and treatment. The explanation and details of the aqua therapy proposed

[14] Applicant's Document Brief, Tabs 4 and 9, undated excerpt from Consultation Report of Dr. Kodabandehloo.
[15] Applicant's Document Brief, Tab 3, excerpt from Consultation Report of Dr. Safania, dated April 5, 2017
[16] Applicant's Document Brief, Tab 6, excerpts from Clinical Notes and Records of Health Max.
[17] Applicant's Document Brief, Tab 9, excerpts from Clinical Notes and Records of Dr. Malisic.
[18] *Supra*, footnote 3, at page 10.
[19] *Supra*, footnote 3.

in the treatment plan and its intended use to assist in alleviating the applicant's pain, is persuasive evidence of the reasonableness of aqua therapy in this case, particularly given the widespread nature of the applicant's pain. Additionally, Dr. DiFonzo, who treated the applicant for chronic pain from March 2018 until July 2018, described the applicant as having generalized chronic pain and notes that in developing her treatment plan, various treatment modalities, including aqua therapy, were discussed[20].

[27] As discussed above, the applicant's entitlement to treatment expenses is limited by s. 38(2) of the *Schedule* to expenses incurred on or after October 17, 2017. As the records from Healthmax[21] establish that the only aqua therapy received after October 17, 2017 was on October 18, 23 and 30, 2017 and on November 1, 2017, the respondent's liability is limited to expenses for reasonable and necessary treatment or services incurred on those dates.

[28] As I find that that aqua therapy is a reasonable and necessary treatment modality in this case, I must now determine whether the specific Aqua Therapy and Rehabilitation Program recommended in the September 28, 2017 treatment plan is reasonable and necessary. The respondent submits that the following components of that treatment plan are not reasonable or necessary:

a. the hourly rate charged for the pool sessions;

b. the facility fees; and

c. the acupuncture treatment recommended.

Reasonableness of the hourly rate charged for the pool sessions

[29] I find that the applicant's entitlement to payment for the pool sessions that occurred after October 16, 2017 is limited to payment at the rate of $58.15 per hour for the following reasons.

[30] The treatment plan sets out a cost of $99.75 per one hour session of pool therapy, the maximum hourly rate permitted under the *Professional Services Guideline*[22] (the "Guideline") for services provided by a physiotherapist. The respondent submits that when the pool sessions were overseen by an unregulated provider, rather than a physiotherapist, the hourly rate should be $58.15. The respondent relies upon the Healthmax treatment records[23] which appear to have been completed by Hussain Nawal ("Nawal"), an individual the applicant confirmed is not a licensed provider[24].

[20] Applicant's Document Brief, Tab 7, Letter from Dr. DiFonzo, dated March 21, 2018.
[21] *Supra*, footnote 11.
[22] Superintendent's Guideline No. 03/14, issued pursuant to s. 268.3(1) of the *Insurance Act,* R.S.O. 1990, C. I.8.
[23] Respondent's Document Brief, Tab 16, Clinical Notes and Records from Healthmax.
[24] Applicant's Reply Submissions, dated November 14, 2018, at paragraph 1.

[31] In her Reply Submissions, the applicant submits that the physiotherapist was present and oversaw the treatment provided, even though the treatment records were completed by Nawal who was present to provide some guidance to the applicant during pool sessions[25].

[32] There is no evidence related to who provided the pool therapy other than the Healthmax's treatment notes. For the pool sessions that occurred on October 18 and 23, 2017 the treatment notes completed by Nawal make no reference to a physiotherapist providing any services. It is unclear from the treatment notes for October 30, 2017 and November 1, 2017 whether both Nawal and a physiotherapist were involved in the pool sessions. The "objective findings" in those treatment notes appear to have been completed by Nawal. Although the physiotherapist's name is printed on the treatment note with a place for her to initial the same, neither the October 30, 2017 nor the November 1, 2017 treatment note is initialled by her. I therefore find that the evidence does not establish that any of the pool services were provided by a physiotherapist and find that the appropriate hourly rate for the pool sessions is $58.15, the Guideline rate for an unregulated provider.

Facility Usage Fee

[33] I do not find the applicant is entitled, under the *Schedule,* to the facility usage fees of $170.00 per pool session set out in the treatment plan for the following reasons.

[34] The treatment plan states that the facility usage fee for each pool session is to provide "pool access, life guard on site and supporting staff to assist with patient need". The applicant provides no further evidence relating to the facility usage fee. The respondent relies upon the Guideline which establishes the maximum expenses payable by an insurer under the *Schedule* "related to the services of health care professionals or health care providers" listed in the Guideline. The respondent submits that there is no reference in the Guideline to facility fees and that it is incumbent on the service provider to negotiate any facilities fee, on behalf of the applicant, with the insurer. The respondent further submits that the cost of the facility usage fee charged is extremely excessive.

[35] The Guideline applies to claims for medical benefits under s. 15(1)(b) of the *Schedule*, including physiotherapy benefits. It defines "expenses related to professional services" as referred to in the *Schedule* and the Guideline, to include all administration costs, overhead, and related costs, fees, expenses, charges and surcharges ("other charges"). The Guideline specifically states that an insurer is not liable for any other charges that have the result of increasing the effective hourly rates beyond what is provided for in the Guideline. It also states that the amounts payable by an insurer related to services not covered by the Guideline are to be determined by the parties involved.

[25] *Ibid.*

[36] As noted by the respondent, there is no reference facility usage fees in the Guideline. I find that there is insufficient evidence to determine whether the facility usage fee is a fee that would be considered an expense related to professional services as defined in the Guideline, or whether the respondent should be relieved of any obligation to pay the same on that basis.

[37] In any event, I find that the applicant has not met her onus of establishing, on the balance of probabilities, that the facility fee of $170.00 per hour is reasonable and necessary. The treatment plan states that the facility usage fee is for "pool access and life guard on site and supporting staff to assist with patient need". As the treatment plan also provides for, and I have allowed, payment for a service provider for each pool session, I find that it is not reasonable for there to be an additional charge for other supporting staff at the pool. Although a reasonable pool access fee may be appropriate in some cases, in this case there is insufficient evidence to establish what portion of the $170.00 facility fee is for pool access, or what a reasonable pool access fee is. Accordingly, I do not find the applicant is entitled to the facility usage fees set out in the treatment plan.

Acupuncture Treatment

[38] I find that there is insufficient evidence to establish that the acupuncture treatment proposed is reasonable and necessary in this case for the following reasons. The September 28, 2017 treatment plan recommends acupuncture treatment and states that "[a]cupuncture can help alleviate chronic pain to help better tolerate manual therapy and exercise…." Unlike the aqua therapy recommended to treat the applicant's multiple areas of pain, there is no indication in the treatment plan of which of the applicant's areas of pain will be targeted by the acupuncture treatment proposed. Additionally, there is insufficient evidence to establish that the applicant had difficulty tolerating manual therapy and exercise that would necessitate acupuncture treatment.

Other components of the treatment plan

[39] The Physiotherapy Initial Assessment recommended in the treatment plan was conducted on September 21, 2017, and the results of the same are set out in the treatment plan. As that service was completed prior to the submission of the treatment plan, the respondent is not liable to pay for the cost of the same.

[40] Included in the services to be provided are 18 sessions of what is referred to as "Hurt vs Harm". This is described further in the "Additional Comments" section of the treatment plan as referring to education that "will be provided on a home exercise program, self care and hurt versus harm". Dr. Abounaja's report indicates that the applicant attended physiotherapy 1 to 2 times a week starting in early January 2017 and that she was continuing to attend 3 times a week when she was assessed in October 2017. Based on the applicant's lengthy prior rehabilitation treatment, which included stretching and exercise, there is

insufficient evidence to establish that additional education on exercise or hurt versus harm is reasonable or necessary.

[41] The treatment plan also includes the cost of a progress report "if needed". Given the finding that the respondent is liable only for the treatment expenses related to some of the pool sessions, I find that a progress report is not necessary, and the same is not reasonable or necessary unless requested by the respondent.

Conclusions relating to the September 28, 2017 treatment plan

[42] For the reasons set out above, I find that the only services recommended in treatment plan dated September 28, 2017 that the evidence establishes is reasonable and necessary and incurred after the treatment plan was submitted on October 16, 2017 are the pool sessions on October 18, 23, and 30, 2017 and November 1, 2017, at an hourly rate of $58.15.

Is the applicant entitled to medical benefits for the chiropractic treatment proposed in the October 3, 2017 treatment plan?

[43] The applicant has not established that the chiropractic treatment recommended in the October 3, 2017 treatment plan, which consists of ten sessions of laser treatment, is reasonable and necessary for the reasons that follow.

[44] The applicant relies on the October 3, 2017 treatment plan completed by Dr. Hassan, a chiropractor.

[45] The respondent relies on Dr. Abounaja's IE Report[26] prepared following an assessment conducted to determine whether a July 31, 2017 treatment plan for chiropractic treatment completed by Dr. Hassan (which did not specifically refer to laser treatment), was reasonable and necessary. Dr. Abounaja's conclusion that further facility-based treatment is not reasonable and necessary, is given little weight in determining the issue of whether the laser treatment recommended is reasonable and necessary as there is no evidence that laser treatment was a treatment modality that was considered by Dr. Abounaja.

[46] Although the treatment plan itself provides information regarding the benefits of laser treatment generally and the physiological effects of targeting concentrations of light several centimetres below the skin's surface, it makes no reference to the applicant's specific circumstances. Having considered the widespread nature of the applicant's pain, and as the treatment plan makes no reference to which of the numerous areas of injury listed in the treatment plan will be targeted with laser treatments, I find that there is insufficient evidence to establish that the laser therapy recommended is reasonable and necessary for the applicant in this case.

Is the applicant entitled to prescriptions expenses in the amount of $117.40?

[26] *Supra*, footnote 3.

[47] I find that the applicant is entitled the prescription expenses for almotriptan in the amount of $117.40 for the following reasons.

[48] The respondent denied the applicant's request for reimbursement of the cost of a prescription for almotriptan, a medication used to treat migraine headaches. The basis for the denial is the respondent's belief that the applicant had had migraine headaches prior to the accident and that therefore, she would have required this prescription regardless of the injuries suffered in the accident[27]. The evidence does not support this basis for denial.

[49] On November 15, 2016, approximately 6 weeks before the accident, the applicant saw her family doctor complaining of headaches, which she had been having for over 2 years with increasing frequency. She had been diagnosed by him with migraine headaches. The family doctor's notes indicate that the applicant did not take any medication for her headaches at that time nor was anything prescribed at that visit[28]. There is no evidence of the applicant ever having been prescribed almotriptan or any other medication for migraine headaches prior to the accident. A Consultation Note from the neurologist, who assessed the applicant on April 5, 2017[29], notes that the applicant had a 2 year history of headaches which worsened after the accident. The applicant was prescribed axert (almotriptan) for her migraine headaches in April 2018[30].

[50] The evidence supports a finding that the applicant's migraine headaches worsened following the accident and that it was only after the accident that she began taking medication for those headaches. I therefore find that the cost of her prescription for almotriptan, in the amount of $117.40, is reasonable and necessary and related to the injuries sustained in the accident.

Is the applicant entitled to medical expenses in the amount of $535.59?

[51] The evidence does not support the applicant's claim for a medical expense in the amount of $535.59.

[52] The applicant claims entitlement to a medical expense in the amount of $535.59 which the applicant submits relates to a claim for elbow braces[31]. The applicant refers to an OCF-6 dated June 18, 2018 that was submitted with receipts totalling $1.049.06[32]. Although there is a prescription dated March 9, 2018 for elbow braces, the corresponding receipt is for $50.60, which expense was approved by the respondent. The only receipt for $535.59 submitted by the applicant is for orthotics and orthopaedic footwear.

[27] Applicant's Documents, Tab A, at pages 59-61, Letter from the respondent to the applicant dated, June 20, 2018.
[28] Respondent's Document Brief, Tab 3, Clinical Notes and Records, Dr. Malisic, dated November 15, 2016.
[29] Applicant's Document Brief, Tab 3, excerpts from the Consultation Note of Dr. Safinia, dated April 5, 2017.
[30] Applicant's Document Brief, Tab 9, Consultation Report of Dr. M. Gawel, dated April 23, 2018.
[31] Applicant's Written Submissions, at paragraph 44.
[32] Applicant's Document Brief, Tab A, at pages 26-48, OCF-6 dated June 18, 2018 with attached receipts.

[53] The respondent's letter dated June 20, 2018[33] denied the applicant's claim for $535.59 for orthotics and orthopaedic footwear on the basis that the applicant did not sustain a foot injury in the accident, and because a treatment plan was not received prior to the applicant incurring this expense.

[54] I find that the applicant has not established entitlement to an expense claim in the amount of $535.59. The only claim submitted for $535.59 relates to orthotics and orthopaedic footwear, which the applicant has not established are needed as a result of injuries sustained in this accident, nor was a treatment plan recommending the same submitted.

Is the applicant entitled to interest?

[55] The applicant is entitled to interest on the costs incurred for pool therapy sessions that occurred on October 18, 23, and 30, 2017 and November 1, 2017 (calculated at an hourly rate of $58.15), and on the $117.40 prescription expense, in accordance with s. 51 of the *Schedule*.

Is the applicant entitled to an award under *Ontario Regulation 664*?

[56] The applicant submits that she is entitled to an award under *Ontario Regulation 664* ("an Award") because the respondent "blindly relied on the final determination of Dr. Abounaja without considering the body of the report" and because it was "patently unreasonable for the Respondent to ignore the content of the report of Dr. Ornstein". The respondent submits that the applicant's claim was handled in good faith, that decisions were made based on available evidence and that there has been no unreasonable delay in paying benefits.

[57] Section 10 of *Ontario Regulation 664* provides the Tribunal with authority to make an Award if the Tribunal finds that an insurer has "unreasonably withheld or delayed payments" of benefits.

[58] Only two pages of a Report by Dr. Ornstein were filed as evidence by the applicant[34]. In his Report, Dr. Abounaja refers to the psychological IE Report dated July 11, 2017 completed by Dr. Ornstein.[35] There is insufficient evidence regarding the content of Dr. Ornstein's Report to make a determination of whether the respondent ignored the content of that Report, as alleged by the applicant, or whether an Award is warranted on that basis.

[59] Although I find that the applicant is entitled to payment for some of the benefits sought in one of the two treatment plans in issue, I do not find that the respondent unreasonably withheld or delayed payments of benefits for the following reasons. The applicant had been assessed by Dr. Abounaja on October 13, 2017, just a few days before the September 28, 2017 treatment plan was

[33] *Supra*, footnote 27.
[34] Applicant's Document Brief, Tab 6, Excerpts from the IE Report of Dr. Ornstein.
[35] *Supra,* footnote 3 at page 10.

submitted on October 16, 2017. Dr. Abounaja had concluded that there was no objective evidence of residual musculoskeletal impairment attributable to the injuries sustained in the accident, that the applicant had reached maximum medical recovery, and that further facility-based treatment was not reasonable or necessary. Although I take a different view than the respondent of the relevance of Dr. Abounaja's findings with respect to the September 28, 2017 treatment plan, that determination does not mean the respondent's reliance on Dr. Abounaja's Report was unreasonable. In the circumstances of this case, I am not persuaded that it was unreasonable for the respondent to rely upon that assessment in denying the treatment plans in dispute given the proximity in time of between Dr. Abounaja's assessment and the date the September 28, 2017 treatment plan was submitted.

[60] I do not find that an award under s. 10 of *Ontario Regulation 664* is warranted in this case.

ORDER

[61] I find that:

(i) The applicant is entitled to receive payment for the pool sessions that occurred on October 18, 23, and 30, 2017 and November 1, 2017, calculated at an hourly rate of $58.15.

(ii) The applicant is entitled to a medical benefit in the amount of $117.40 for prescription expenses.

(iii) The applicant is entitled to interest in accordance with s. 51 of the *Schedule* on any benefits payable under (i) and (ii) above.

(iv) The applicant is not entitled to an award under *Ontario Regulation 664*.

(v) The applicant is not entitled to any of the other medical benefits claimed.

Released: July 9, 2019

Amanda Fricot, Adjudicator