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

Ontario

2020 CanLII 14422 (ON LAT)

Citation: J.P. vs. Allstate Insurance Company, 2020 ONLAT 18-008027/AABS

Tribunal File Number: 18-008027/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:

J.P.

Applicant

and

Allstate Insurance Company

Respondent

DECISION

ADJUDICATOR: **Jesse A. Boyce**

APPEARANCES:

Counsel for the Applicant: Ramy Akladios

Counsel for the Respondent: Ryan Kirshenblatt.

WRITTEN HEARING: **May 27, 2019**

OVERVIEW

[1] J.P. was injured in an accident on July 6, 2017 and sought benefits from the respondent, Allstate, pursuant to the *Statutory Accident Benefits Schedule – Effective September 1, 2010*[1] ("*Schedule*").

[2] J.P. sought medical and rehabilitation benefits from Allstate as well as payment of an income replacement benefit ("IRB"). The IRB was initially paid and then denied by Allstate when it determined J.P. no longer met the criteria for an IRB for the period in dispute. Allstate denied the medical and rehabilitation benefits on the basis of s. 38(5) of the *Schedule*. J.P. disagreed with Allstate's decision and submitted an application to the Tribunal for reinstatement of the IRB.

[3] The parties participated in a case conference but were unable to resolve their dispute, after which they proceeded to this hearing.

ISSUES TO BE DECIDED

[4] The following are the issues to be decided, as per the Case Conference Order dated January 10, 2019:

i. Is the applicant entitled to the weekly income replacement benefit in the amount of $383.21 from November 29, 2017 until April 22, 2018?

ii. Is the applicant entitled to a medical benefit in the amount of $2,547.81 for physiotherapy treatment recommended by Toronto Health Care Clinic Inc. in a treatment plan (OCF-18) submitted on July 27, 2017, and denied on August 4, 2017?

iii. Is the applicant entitled to a medical benefit in the amount of $1,465.10 for physiotherapy treatment recommended by Toronto Health Care Clinic Inc. in a treatment plan (OCF-18) submitted on September 19, 2017, and denied on October 3, 2017?

iv. Is the applicant entitled to a medical benefit in the amount of $1,566.80 for physiotherapy treatment recommended by Toronto Health Care Clinic Inc. in a treatment plan (OCF-18) submitted on October 26, 2017, and denied on November 9, 2017?

v. Is the applicant entitled to a medical benefit in the amount of $1,800 for shock wave therapy treatment recommended by Toronto Health Care Clinic Inc. in a treatment plan (OCF-18) submitted on January 12, 2018 and denied on January 29, 2018?

vi. Is the applicant entitled to a medical benefit in the amount of $1,225.10 for physiotherapy treatment recommended by Toronto Health Care Clinic

[1] O. Reg. 34/10.

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Inc. in a treatment plan (OCF-18) submitted on January 12, 2018, and denied on January 29, 2018?

vii. Is the applicant entitled to a medical benefit in the amount of $1,143.74 for physiotherapy treatment recommended by Toronto Health Care Clinic Inc. in a treatment plan (OCF-18) submitted on February 6, 2018 and denied on February 22, 2018?

viii. Is the applicant entitled to the cost of examination in the amount of $1,340.20 for functional impairment evaluation recommended by Toronto Health Care Clinic Inc. in a treatment plan and assessment plan (OCF-18) submitted on October 26, 2017 and denied on November 9, 2017?

ix. Is the applicant entitled to the cost of examination in the amount of $2,000 for chronic pain assessment recommended by Toronto Health Care Clinic Inc. in a treatment plan and assessment plan (OCF-18) submitted on January 19, 2018 and denied on February 2, 2018?

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

xi. Is the applicant entitled to an award under Ontario Regulation 664 because the respondent unreasonably withheld or delayed the payment of benefits?

RESULT

[5] J.P. is not entitled to an IRB in the amount of $383.21 per week for the period in dispute as he has not demonstrated that he has a substantial inability to perform the essential tasks of his employment.

[6] J.P. is not entitled to any of the treatment or assessment plans in dispute as they were properly denied under s. 38(5) of the *Schedule* and are not subject to review under s. 38(6).

ANALYSIS

Is J.P. entitled to an income replacement benefit?

[7] I find J.P. is not entitled to an IRB for the period in dispute. I find the medical documentation and other evidence does not satisfy J.P.'s onus to prove that he suffers a substantial inability to perform the essential tasks of his employment.

[8] Entitlement to an IRB falls under s. 5(1)(1)(i) of the *Schedule*: an IRB is payable if the insured was working at the time of the accident and, within 104 weeks of the accident, suffers a substantial inability to perform the essential tasks of that employment. This inquiry is divided into two steps: 1) what are the essential tasks of employment? and, 2) is the insured substantially unable to perform the

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essential tasks of that employment? The onus to prove entitlement rests with the applicant.

[9] At the time of the accident, J.P. was employed as a car washer at […]. The job profile provided indicates his work was full-time and consisted of bending, stooping, standing, sitting, walking, turning and pivoting into various positions over the course of the day in order to clean the inside and outside of vehicles and drive them. On average, the job required him to do these tasks, in addition to lifting and pulling equipment up to 50 pounds, approximately three-to-five hours per day, five days a week. J.P. had been employed in this capacity since 2009. Prior to terminating the benefit on November 29, 2017, Allstate paid J.P. approximately $7,700 in IRBs. J.P. reports returning to work at […] on April 23, 2018. In his affidavit, J.P. submits that, as a result of the accident, the pain in his neck, knees and lower back cumulatively prevented him from performing these essential work tasks.

[10] In response, Allstate contends that J.P.'s physical injuries are predominately soft-tissue injuries that do not render him substantially unable to complete his essential work tasks for the period in dispute and, further, that J.P. has not provided persuasive medical evidence indicating that he had an occupational disability during the period in dispute and, even if he did, that Allstate is entitled to a deemed deduction and the IRB payable is only $46.70 per week. I agree with Allstate.

[11] First, I find the note from J.P.'s family physician, Dr. Rampersad, stating that J.P. cannot work to be underwhelming medical evidence of a substantial inability to complete the tasks identified above. The note, dated July 7, 2017, simply states that J.P. is "unable to work due to medical reasons" but does not identify the medical reasons and does not provide a diagnosis. Further, the note indicates that J.P. would attend for a re-assessment on July 18, 2017 but there are no notes that follow, and no update provided from Dr. Rampersad's office indicating J.P. went in for a follow up or procured further medical notes. While attendance records indicate that J.P. attended for physiotherapy immediately after the accident, this is not medical evidence confirming a substantial inability to perform the tasks of his employment.

[12] Second, the OCF-3 prepared by Dr. Minella, chiropractor, lists sprains, strains, headache and pain as the predominant physical injuries as a result of the accident, which can all be characterized as minor physical injuries under the *Schedule*. Yet, despite the fact the physical injuries identified are minor, Dr. Minella checks the box that J.P. *suffers from a complete inability to carry on a normal life* due to his limitation with "all aspects of his ADLs" and that the anticipated duration of his injuries would exceed 12 weeks. While it is true that J.P. did not return to work until April 2018, I find this opinion is not proportional to the medical evidence and does not identify the activities of daily living or employment that J.P. is limited at. In my view, this lack of proportionality affects the weight I assigned to Dr. Minella's opinion, especially considering his findings

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in the Functional Abilities Evaluation report from November 2017, where he found J.P. could handle light duties, but then proceeded to check the box for the much more stringent Non-Earner Benefit test.

[13] Third, I find the other "medical" evidence relied on by J.P. to prove that he has a substantial inability to perform his essential work tasks is all a result of self-reporting. Put another way: there is limited objective medical evidence before the Tribunal that his impairments prevented him from completing his work tasks during the claim period. For example, in submissions on his IRB entitlement: J.P. cites his own affidavit describing his pain; Dr. Rampersad's note excusing him from work which was based on his self-reporting the day after the accident with no follow-up; the OCF-3 of Dr. Minella; his self-reporting to Dr. Ilios and a vague statement that "treating physicians upon assessment have opined that s. 5(1)(i) of the *Schedule* is applicable" without citing these opinions. Further, while not determinative, Allstate submits that J.P. did not secure prescriptions for any pain medication for his impairments during the period in dispute, despite his contention that his physical pain was preventing him from completing his essential work tasks like bending, sitting and driving.

[14] Finally, I find it notable that Allstate paid IRBs to J.P. for approximately four months post-accident. In my view, this is an indication that Allstate believed that his impairments were preventing him from completing his work tasks post-accident. However, I reiterate that it is J.P.'s burden to prove continuing entitlement for the period in dispute. On the medical evidence before the Tribunal, I find no reason to interfere with Allstate's determination to stop the IRBs as there is limited medical evidence beyond J.P.'s self-reporting indicating an occupational disability. I find J.P. has failed to meet his onus to prove that he is entitled to an IRB for the period in dispute because there is no medical indication that he cannot perform the essential tasks of his pre-accident employment.

Are the treatment plans in dispute reasonable and necessary?

[15] Section 14 of the *Schedule* provides that an insurer is liable to pay for medical and rehabilitation benefits that are reasonable and necessary as a result of an accident. The applicant bears the onus of proving, on a balance of probabilities, that each treatment and assessment plan is reasonable and necessary.

[16] However, Allstate argues that it denied all the treatment plans and costs of assessments in dispute based on s. 38(5) of the *Schedule* and, as a result, pursuant to s. 38(6), the denials are not subject to review by the Tribunal. I agree.

[17] Section 38(5) states that an insurer may refuse to accept a treatment and assessment plan if the plan describes goods or services to be received or an assessment or examination to be conducted in respect of any period during which the insured person is entitled to receive goods or services under the

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Minor Injury Guideline ("MIG") in respect of the impairment. Section 38(6) then states that an insurer's refusal to accept a treatment and assessment plan under ss. (5) is final and is not subject to review.

[18] On review of the evidence, all eight treatment plans in dispute were submitted by J.P. between July 7, 2017 and January 27, 2018. During this period, Allstate had determined that he was in the MIG. Allstate argues that its position was based on J.P.'s paucity of evidence, as the first four treatment plans it denied under s. 38(5) were only supported by a disability certificate listing minor injuries. Meanwhile, the latter treatment plans in dispute were denied on the basis that Allstate believed J.P.'s injuries were subject to the MIG due to uncompelling medical evidence, the fact the MIG limit had not been exhausted and he did not submit his claims via an OCF-23. Accordingly, in response to all of these OCF-18s, I find Allstate provided proper denials in the form of OCF-9s, all of which relied on the same reason: "As per section 38(5) of the SABS, we are refusing to accept the OCF-18 based on MIG and request you submit an OCF-23."

[19] It is not disputed that J.P. was in the MIG when he submitted all the disputed OCF-18s. When subject to the MIG, insureds are required to submit treatment through OCF-23s—otherwise known as a Treatment Confirmation Form—and not OCF-18s, in order to access the initial block of treatment funding. This legislative prohibition is designed to ensure that insureds exhaust the funding in the MIG or are removed from the MIG before receiving treatment beyond the $3,500 limit. On the facts, J.P. did not submit his treatment via OCF-23s, as Allstate requested, but through OCF-18s, which Allstate properly denied on the basis that it believed he was in the MIG and that it required OCF-23s in order to process funding quickly.

[20] Further, on the evidence and as Allstate submits, J.P. had not even come close to exhausting the MIG funding limit at the time of the denials, despite arguing that he required treatment beyond it. Indeed, according to Allstate, it had only paid $63.72 towards medical and rehabilitative benefits as of January 2019, and J.P. was not removed from the MIG until January 10, 2019. While I find J.P.'s attendance at Toronto Healthcare Clinic is documented and note Allstate has made further payments since removing him from the MIG, it remains unclear why he continued to submit OCF-18s while subject to the MIG, especially if he was incurring treatment, as alleged. Additionally, despite having the opportunity to do so for this hearing, J.P. did not advise why he refused to submit treatment via OCF-23s after repeated requests by Allstate to do so.

The Tribunal's request for submissions

[21] I find Allstate issued valid denials of the OCF-18s pursuant to s. 38(5) and s. 38(9), and note that s. 38(6) expressly prevents the Tribunal from reviewing denials on this basis. However, in November 2019, the Tribunal reached out to the parties for further submissions on the applicability of Allstate's denials under

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s. 38(5) notwithstanding J.P.'s later removal from the MIG in January 2019. The Tribunal also asked for clarification on the amounts remaining in the MIG and what amounts J.P. has incurred for treatment.

[22] The parties provided timely submissions. On review of these submissions, J.P. did not provide arguments as to why Allstate's refusals under s. 38(5) should be subject to review by this Tribunal under s. 38(6). Instead, his submissions focused on the applicability of ss. 38(8) and (11), how the 10-day notice period should inform s. 38(5) and, ultimately, why he believes Allstate's notices were deficient. While I am alive to all of his submissions, I find none of his arguments overcome the fact that he failed to provide compelling medical documentation, failed to submit treatment via OCF-23s despite repeated requests to do so, and did not exhaust the MIG funding that was available to him despite urging that he needed more. All of this aside, his submissions did not address the Tribunal's specific question. Accordingly, I find no reason to interfere with Allstate's denials of the treatment plans under s. 38(5) and find that they are not subject to review by this Tribunal under s. 38(6), regardless of the fact J.P. was later removed from the MIG by Allstate.

Non-compliance with s. 38(8)

[23] In its submissions, Allstate concedes that two of its denials—dated January 29, 2018 and February 22, 2018—were delivered to J.P. past the 10-day period under s. 38(8) and agrees that J.P. is entitled to payment for any treatment incurred during the period before it cured the defect, being one and two days, respectively. Further, Allstate concedes that it cannot rely on the MIG for any future denials as a result. In response, J.P. argues, incorrectly, that Allstate cannot rely on the MIG and all its denials that rely on its "unsubstantiated" MIG position are deficient. I disagree. Contrary to J.P.'s position, Allstate is only prohibited from relying on the MIG for future treatment plans as there is no retroactive component.[2] Additionally, Allstate is only required to remit payment for treatment incurred during the defective period.

[24] With regards to the two late denials and what has been incurred, J.P. submits that he incurred $357.29 of the February 3, 2018 treatment plan in the amount of $1,143.74, denied by Allstate on February 22, 2018. However, his submissions are silent on how much of the $357.29 was incurred during the two days of Allstate non-compliance. Similarly, his submissions do not indicate whether he incurred any of the treatment for the January 12, 2018 treatment plan that was denied one day late by Allstate. Accordingly, no amounts are payable.

[2] *Zheng, Cai v. Aviva Insurance Company of Canada*, 2018 ONSC 5707.

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Award and Interest

[25] J.P. claims entitlement to an award under s. 10 of Ontario Regulation 664 on the basis that Allstate unreasonably withheld payment of the treatment plans and kept him in the MIG when the documentation indicated he should be out of the MIG. Under s. 10, the Tribunal may issue an award of up to 50 per cent of the amount to which J.P. is entitled if the Tribunal finds that Allstate has unreasonably withheld or delayed payments because of its conduct.

[26] On the facts and evidence before me, I find an award is not appropriate. First, Allstate was within its rights under the *Schedule* to deny the OCF-18s because J.P. did not submit his treatment via an OCF-23 where the *Schedule* requires. Second, I agree with Allstate that J.P. had not justified treatment beyond the MIG for any of the first four treatment plans he submitted. Third, J.P. had not even exhausted the MIG funding despite arguing that he was entitled to treatment beyond the $3,500 cap. Fourth, s. 38(6) is clear that a denial under s. 38(5) is not reviewable by the Tribunal. While J.P. may disagree, I find there was nothing improper about Allstate's handling of the file and, in my view, nothing amounting to unreasonable conduct or bad faith sufficient to warrant an award. Accordingly, I decline to order an award.

[27] As no benefits are overdue, it follows that no interest is payable under s. 51.

CONCLUSION

[28] For these reasons, I find J.P. is not entitled to an IRB for the period in dispute as he does not suffer a substantial inability to perform the essential tasks of his pre-accident employment.

[29] I find J.P. is not entitled to any of the treatment or assessment plans in dispute as Allstate issued valid denials under s. 38(5) and s. 38(6) prevents the Tribunal from reviewing the denials.

[30] I find J.P. is not entitled to an award or interest.

Released: January 9, 2020

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Jesse A. Boyce
Adjudicator

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