Tribunals Ontario
Licence Appeal Tribunal

Tribunaux décisionnels Ontario
Tribunal d'appel en matière de permis

Citation: Thomas v. CUMIS General Insurance Company, 2021 ONLAT 20-000477/AABS

Released Date: 06/02/2021
File Number: 20-000477/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:

Carolene Thomas

Applicant

and

CUMIS General Insurance Company

Respondent

DECISION AND ORDER

ADJUDICATOR: **Monica Chakravarti**

APPEARANCES:

For the Applicant: Adam Moftah, Counsel

For the Respondent: Brendan T. Sheehan, Counsel

HEARD: **Via Written Submissions**

OVERVIEW

[1] The applicant was involved in an accident on June 27, 2017 and sought benefits from the respondent pursuant to the *Statutory Accident Benefits Schedule* – effective September 1, 2010 (the "*Schedule*"). The respondent denied the benefits and the applicant disagreed and applied to the Tribunal for resolution of the dispute.

ISSUES IN DISPUTE

[2] A final case conference took place on September 18, 2020 and an Order was issued setting out the issues in dispute for this hearing. The issues in dispute identified in the Order of September 18, 2020 were the below substantive issues and a preliminary issue raised by the respondent that the applicant's claim for accident benefits is statute barred pursuant to section 61(1) of the *Schedule*. The respondent confirmed that the preliminary issue of section 61(1) is no longer an issue to be decided in this hearing.

[3] The respondent is now seeking a finding that a physiotherapy treatment plan in dispute is statute barred. Thus, this is a new issue in dispute that was not part of the Order of September 18, 2020 and is raised for the first time in the submissions of the respondent. It would be procedurally unfair to allow the respondent to unilaterally vary the Order of the Tribunal by adding this as an issue to this hearing. As well, based on the decision below, the issue of the applicant being statute barred pursuant to section 56 is moot as ultimately the physiotherapy treatment plan is not reasonable and necessary and therefore not payable.

[4] As per the Tribunal's Order of September 18, 2020 the issues to be decided in this hearing are:

i. Are the applicant's injuries predominantly minor as defined in s. 3 of the *Schedule* and therefore subject to treatment within the $3,500.00 limit and in the Minor Injury Guideline (MIG)?

ii. Is the applicant entitled to $2,181.40 for physiotherapy recommended by an unknown provider in a treatment plan - OCF-18 (Plan) submitted on December 14, 2017, and denied on January 3, 2018?

iii. Is the applicant entitled to $1,998.00 for chiropractic treatment recommended by an unknown provider in a Plan submitted on March 27, 2018, and denied on May 2, 2018?

iv. Is the applicant entitled to $1,998.80 for medical services recommended by an unknown provider in a Plan submitted on March 27, 2018, and denied on May 17, 2018?

v. Is the applicant entitled to $2,200.00 for psychological services recommended by an unknown provider in a Plan submitted on April 11, 2018, and denied on May 11, 2018?

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

RESULT

[5] The applicant's injuries fall within the MIG and therefore subject to treatment within the $3500.00 limit. The applicant has not met her onus to show that the treatment plans in dispute are reasonably necessary and therefore none of the disputed Plans are payable. As no benefits are overdue there is no entitlement to interest.

ANALYSIS

a) *The Minor Injury Guidelines*

[6] The onus is on the applicant to prove on a balance of probabilities that she did not sustain predominately minor injuries as a result of the accident.[1]

[7] Section 18(1) of the *Schedule* provides that medical and rehabilitation benefits are limited to $3,500 if the insured sustains impairments that are predominantly a minor injury in accordance with the MIG. Section 3(1) defines a "minor injury" as "one or more of a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury." It is recognized that psychological injuries, concussion and chronic pain fall outside the definition of minor injury.

[8] Section 15(1) of the *Schedule* provides that, subject to Section 18, the insurer shall pay for all reasonable and necessary medical expenses incurred by or on behalf of the insured person as a result of the accident.

[9] The applicant submits that as a result of the accident she sustained a concussion which removes her from the MIG. The applicant relies on the clinical notes and records of Dr. Talwalkar and High Mark Medical.

[1] *Scarlett v. Belair Insurance,* 2015 ONSC 3635.

[10] The respondent submits that there is no diagnosis of a concussion and the notation regarding concussion in Dr. Talwalkar's notes of July 4, 2017 is the applicant self reporting a concussion. Dr. Talwalkar makes no further recommendations for concussion treatment and there are no further notations, medical notes etc. following July 4, 2017 indicating that the applicant is having headaches or any post-concussive symptoms.

[11] The applicant has the evidentiary onus to prove on a balance of probabilities that she sustained a concussion as a result of the accident. She has not met her onus as she has not provided evidence showing a diagnosis of concussion. She only self reports a concussion to her doctor, Dr. Talwalkar, on July 4, 2017. She states this was diagnosed at High Mark Medical, however, the note from High Mark Medical is a note stating that she cannot return to work until July 5, 2017 with no indications of injuries let alone a concussion.

[12] Further, by July 4, 2017, i.e. within a week of the accident, she reports to Dr. Talwalkar that her headaches are improving. The CT scan of her brain on September 21, 2017 is normal. Other than the note of July 4, 2017 there are no complaints or evidence of headaches or anything that could be construed as a concussion or concussive symptoms.

[13] Therefore, the applicant has not met her onus that she sustained a concussion as a result of the accident.

[14] The applicant submits that she has ongoing pain as a result of accident related injuries and therefore requires ongoing access to treatment to assist with her continuous pain. Thus, she should be removed from the confines of the MIG.

[15] The respondent submits that there is no evidence that the applicant has chronic pain as a result of the accident.

[16] It is established that chronic pain is not a minor injury as defined in the *Schedule* and therefore not subject to the confines of the MIG. The applicant again has the evidentiary burden of proving on a balance that as a result of the accident and accident related injuries that her pain has developed into chronic pain.

[17] The evidence shows that the applicant had initial complaints of pain. On July 4, 2017 the applicant reports to Dr. Talwalkar pain in her shoulder and upper back. She also reports to Dr. Talwalkar that on the day of the accident she went to the hospital from the scene of the accident due to her knee pain.

[18] Then on August 21, 2017 Dr. Talwalkar conducts a physical examination and makes no findings of any issues with the applicant's musculoskeletal system or joints as follows:

> Musculoskeletal system both knees are normal no effusion FULL ROM NO PAIN. Lumbosacral spine full range of movement. Cervical spine full range of movement and no tenderness.

[19] On this date, August 21, 2017, the applicant requests an x-ray and Dr. Talwalkar indicates that he will requisition the x-rays however "she has a normal physical exam as far as joints are concerned." It is noted that on August 21, 2017 there are no pain complaints made by the applicant to Dr. Talwalkar.

[20] The applicant points me to the clinical note of October 25, 2017 as evidence of ongoing pain. Again, there are no complaints of pain being made by the applicant to Dr. Talwalkar on this day and the doctor finds that the applicant's cervical and lumbar spine has full range of motion.

[21] The next record the applicant relies upon as evidence of her ongoing and continuous pain is on July 9, 2020, three years post-accident. There are no records provided between October 25, 2017 and July 9, 2020 showing or speaking of pain complaints.

[22] On July 9, 2020 the applicant is complaining to a new doctor, Dr. Shahzad, of mid low back pain remitting/relapsing current flare up past few days. In this note there is no mention of an accident and this note is three years following the accident and is not persuasive to show that the applicant has ongoing pain as a result of the accident.

[23] The applicant has not met her onus to show that she has chronic pain as a result of the injuries sustained in the accident. The evidence above shows that the applicant had initial complaints of pain following the accident however the evidence does not show that the pain continued. For three years the applicant never sought or received any medical treatment for accident related pain complaints. Therefore, the applicant has not met her onus and she remains within the confines of the MIG.

b) *The Plans and Interest*

[24] The Plans in dispute are for physiotherapy, chiropractic services and psychological services. The last plan relates to "medical services," however, the medical services are not specified.

[25] The respondent submits that the Plan for “medical services” is a treatment plan for an orthopaedic assessment and the Plan for chiropractic treatment is for a chronic pain assessment. This cannot be confirmed as the applicant has failed to provide a response to this submission and failed to provide the Plans in dispute despite the Tribunal requesting same. The onus is on the applicant to dispute the denials that she wants to dispute at the Tribunal. The Tribunal cannot assume that the applicant is disputing a denied treatment plan and then render a decision on said treatment plan. If the applicant has not properly disputed the denial of the treatment plans for an orthopaedic assessment and a chronic pain assessment, then it is not properly in front of the Tribunal to consider in this hearing.

[26] The applicant has the onus of proving on a balance that the disputed Plans are reasonable and necessary. Despite this onus the applicant failed to provide the Plans. The Tribunal requested that the applicant file the Plans. The respondent had the benefit of reviewing the Plans and the Tribunal should have been afforded the same opportunity in order to have a complete picture[2] especially when it is unclear what treatments (or as the respondent submits; assessments) are recommended in the disputed Plans. Copies of the Plans were not ordered but requested from the applicant as it was also unclear if the applicant was relying upon the Plans as evidence in her case. Upon requesting same the Tribunal was told that the Plans were not accessible by the applicant. The Tribunal granted an extension to file same and the applicant still did not produce the Plans. As the applicant did not file the Plans and made no reference to them in her submissions and filed no reply submissions, despite the respondent pointing out that the Plans were not produced, I find that the Tribunal has satisfied itself that the applicant is not relying upon the Plans as evidence in this hearing.

[27] With respect to the Plan for psychological treatment there is no evidence provided by the applicant to show that she has any psychological or emotional complaints. The few medical records provided by her as evidence make no mention of any psychological or emotional issues following the accident and therefore without any evidence to corroborate or show the need for treatment as a result of the accident the applicant has not met her onus to show that the Plan for psychological services is reasonable and necessary and therefore the Plan for psychological treatment is not payable.

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[2] *J.R. v Certas Home and Insurance Company,* 2018 CanLII 13161 (ON LAT) (Reconsideration Decision)

[28] With respect to the Plan for “medical services”, dated March 27, 2018 the applicant has not provided any evidence as to what the plan for the medical services entails and how it is reasonable and necessary. Therefore, the applicant has not met her onus to prove that this Plan for “medical services” is reasonable and necessary and it is therefore not payable.

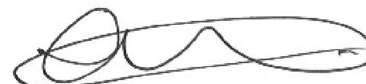
[29] With respect to the Plans for physiotherapy treatment and the Plan for chiropractic treatment again the applicant has not provided the Plans despite the Tribunal requesting same and granting an extension for the applicant to provide same. As well the applicant points to no evidence recommending physiotherapy or chiropractic treatment nor does she point to any evidence on accident related injuries that requires treatment. There are no complaints of pain related to accident related injuries past July 4, 2017. There are three years where the applicant does not seek any medical attention regarding her accident related injuries and there is no evidence that she requires, or it is reasonable for her to engage in physical or chiropractic therapy as a result of accident related injuries. The applicant has not met her onus to show that the Plan for physiotherapy and the Plan for chiropractic treatment is reasonable and necessary and therefore these Plans are not payable.

[30] As none of the Plans are reasonable and necessary there is no entitlement to interest as no benefits are owing to the applicant.

CONCLUSION

[31] The applicant’s appeal is dismissed in its entirety.

Released: June 2, 2021



Monica Chakravarti
Adjudicator