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Ontario

Date: 2017-05-18
Tribunal File Number: 16-002285/AABS
Case Name: 16-002285 v Allstate Insurance Company

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:

Applicant

Applicant

and

Allstate Insurance Company

Respondent

DECISION

ADJUDICATOR: **Monica Purdy**

APPEARANCES:

Counsel for the Applicant: **Baldeep Virk**

Counsel for the Respondent: **Jennifer Griffiths**

Heard by Teleconference: **January 19, 2017**

REASONS FOR DECISION AND ORDER

OVERVIEW

1. The applicant was seriously injured in a motor vehicle accident on July 5, 2013. The parties agreed that the applicant sustained a catastrophic impairment as a result of the accident. . The applicant applied for and received benefits under the *Statutory Accident Benefits Schedule – Effective September 1, 2010* (the "Schedule") including medical and attendant care benefits.

2. The applicant provided an attendant care assessment to the respondent on October 10, 2014 that identified a need for in excess of the statutory maximum of $6,000.00 per month of attendant care services. The respondent is prepared to pay up to statutory maximum but takes the position that it is only obliged to pay the amounts actually invoiced by attendant care providers. Those amounts have been substantially less than the maximum.

3. The applicant takes the position that once she has paid <u>any</u> amount for attendant care benefits and thereby incurred an economic loss, she is then entitled to the maximum payment of $6,000, notwithstanding that she did not incur expenses in that amount.

4. The question I am asked to resolve is whether the respondent is liable to pay the full amount of the assessed attendant care needs or is its liability limited to the invoiced costs actually incurred by the applicant? I find that the respondent is only liable to pay the attendant care amounts that have been incurred by the applicant.

5. I am also asked to resolve a dispute over payment for two neuropsychological treatment plans. The applicant claimed that each of the two treatment plans, for $2,200, were distinct from the other. Both treatment plans were submitted to the respondent on the same day by the same assessor. The applicant submits that the two assessments are distinct from each other and, each should be considered separately and the insurer considered them as one. In order to obtain a diagnosis, neuropsychometric testing was required along with a neuropsychological assessment.

6. The applicant also argued that the insurer failed to provide medical reasons as required by 38(8) of the Schedule when they denied the neuropsychological testing treatment plan.

7. The respondent takes the position that the treatment plans comprise one assessment and that issue is around the cost of examinations. It submits that the service provider has attempted to work around the $2,000.00 cap applicable to such assessments by breaking the assessment into two parts in order to maximize the amount that can be charged for the work. The respondent states that it is not a failure to provide medical reasons. The issues involves the cost of examination under 25(5).

8. I am asked to decide if the treatment plan was simply part of one assessment and if the respondent provided a medical reason in its denial of the treatment plan. My decision is as follows:

RESULTS

1. The applicant is not eligible to receive attendant care benefits in excess of the amounts incurred.
2. The applicant is not entitled to the cost of examination of a neuropsychological assessment.
3. The applicant is not entitled to interest.

LAW AND ANALYSIS

Attendant Care Benefits

9. In order to qualify for attendant care benefits the applicant must meet the test under s. 19. (1) & (2) which states:

   (1) Attendant care benefits shall pay for all reasonable and necessary expenses that are incurred by or on behalf of the insured person as a result of the accident for services provided by an aide or attendant or by a long-term care facility

   (2) The amount of a monthly attendant care benefit is determined in accordance with the version of the document entitled “Assessment of Attendant Care Needs.

10. Section 3 (7) (e) of the Schedule sets out that an expense is not incurred unless:
    a. The insured person has received the goods or service to which the expense relates,
    b. The insured person has paid the expense, has promised to pay the expense or is otherwise legally obligated to pay the expense, and
    c. 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 accidents or (b) sustained an economic loss as a result of providing the goods or services to the person.

11. The applicant submitted an Application for Expenses (OCF 6) dated March 3, 2015. It indicates a need for attendant care expenses for $8,541.81 that is based on the Assessment of Attendant Care Needs (Form 1) completed on September 24, 2014. The statutory maximum amount for attendant care for someone who has sustained a catastrophic impairment is $6,000.00 per month. The applicant was assessed and approved for 24 hours of daily attendant care needs. Invoices from Access Personal Support, one of 3 service provider agencies that the applicant uses, list the amount of hours and the dates that attendant care was provided.

12. The applicant received a total of 12 hours of services over the following 4 dates: February 9, 13, 23, and 27, 2015 at the cost of $528.84 for the month. Although the respondent approved and issued payments for $528.84, neither the full amount of $8541.83 that the applicant requested nor the $6,000.00 statutory maximum was paid.

13. The applicant's position is that she is entitled to attendant care benefits at the maximum amount of $6,000 per month from December 13, 2014 to date and ongoing. Since December 13, 2014, the respondent has only paid the amounts of the invoices submitted by the professional service providers and has refused to pay the amount claimed on the Application for Expenses form (OCF 6).

14. The respondent challenges the applicant's entitlement to the amount of attendant care benefits being claimed as the full amount listed has not been incurred. The respondent takes the position that there is no obligation on its part to pay for services that were not actually provided to the insured, or in respect of which an expense was not proven to be incurred. The respondent notes that the rate of attendant care is not solely determined by the Form 1 amount.

15. The respondent also submits that the applicant has not incurred any additional expenses for care beyond those that have been submitted and paid for by the insurer. For the period of December 12, 2014 to the date of the hearing, the respondent has approved all attendant care services for which invoices were provided by professional aides. The balance of the amounts claimed by the applicant was denied due to the fact there was no proof that the services were provided and incurred.

16. Both section 19 and section 3 (7) of the Schedule make it clear that attendant care benefits have to be incurred by the person in order to obtain benefits. When a request for attendant care benefits is made by an applicant, the law requires that the person must have actually received the care, promised to pay or have paid for the services. Section 19(2) indicates how the amount of attendant care benefit is calculated based on the Assessment of Attendant Care Needs form.

17. A completed Assessment of Attendant Care Needs is used to assess the need for attendant care benefits and the types of goods and services the person may require. While the Assessment of Attendant Care Needs shows what the applicant's attendant care needs are, it does not show which of the services the applicant actually uses or the costs they actually incur. The invoices in this case show that the applicant used 3 hours on each visit and sometimes as much as 16 hours per month.

18. Among my review of the parties' submissions were several decisions. I find the following three the most relevant to this case.

19. The applicant cited the Court of Appeal case of Henry v Gore Mutual Insurance Company[1], The applicant relied on this case to support their position that attendant care benefits once incurred entitles an injured person to the full amount set out in the Assessment of Attendant Care Needs form[2].

20. In Henry, the court examined the definition and test for economic loss when attendant care services are provided by a family member. The court stated that economic loss was a threshold decision which triggers an obligation for an insurer to pay according to the Form 1 amount even if the actual economic loss was less.

21. I find that Henry and Gore is easily distinguishable from this case in a number ways. First in Henry, it was the mother, a non-professional care provider, who provided the attendant care. Secondly, as the respondent argues there was a clear need for 24 hours of attendant care by the injured person. He required the full complement of services that was recommended on the Form 1. Thirdly, the mother had to take a leave of absence from her job, thereby, incurring an economic loss to provide the care. Most significantly, the Schedule was amended in February 1, 2014 to now clarify that claims for attendant care by non-professionals are limited to the actual economic loss sustained.

22. The respondent offered that Motor Vehicle Accident Fund v Veley, FSCO Appeal P14-00021 is more applicable to this case. The appeal decision overturned a previous decision in which the full amount of the Assessment of Attendant Care Needs was awarded despite invoices showing lower amounts of incurred attendant care. The decision made the distinction between the maximum amount of benefits that is available on the Assessment of Attendant Care Needs form and the actual amount of benefits that is payable. The actual amount of benefits that is payable on any given month depends on expenses that have been incurred.

[1] 2013 ONCA 480.

[2] The applicant cited *Henry v. Gore*; however, that case dealt specifically with expenses as they relate to services provided by a non-professional. The services in this case were provided by a professional, so the case is inapplicable. Furthermore, *Henry v. Gore* is no longer applicable, because of the passing of *Ontario Regulation 347/13*.

23. The case of Toronto Transit Commission Insurance Company Limited and The Estate of Reuben Marcus (FSCO Appeal P14-00005, September 19, 2014), dealt with a professional caregiver. The arbitrator reasoned that:

> It is no longer good law, subject to subsection 3(8), that an insured person need not actually have received the goods or services to which the expense relates, or have paid, promised to pay or be otherwise legally obligated to pay the expense to be entitled to payment of the benefit. To decide otherwise would render clause 3(7) (e), and subsection 3(8), of the 2010 Schedule meaningless.

24. In the current case, there is no indication from the applicant that the full complement of services listed on the Assessment of Attendant Care Needs were ever incurred. Further there was no indication that the applicant received all of the services that were listed on the form. The Assessment of Attendant Care Needs form sets out the range of services that are available to the applicant according to the applicant's attendance care needs. But, for entitlement to the full amount, $6,000, allowed under the legislation, the expenses must be incurred.

25. The Assessment of Attendant Care Needs form amounts were denied by the respondent because only some of the care needs available to the applicant on the Assessment of Attendant Care Needs form were used and therefore incurred. The evidence shows that the applicant incurs approximately 10 to 16 hours of attendant care services each month. These amounts are paid based on the invoices submitted by her professional care providers.

26. I find the complete range of services set out in the Assessment of Attendant Care Needs form were not incurred. As such, the appellant is not entitled to payment of the full amount as listed, but only for the actual expenses incurred.

Cost of Examinations for Treatment Plans dated March 30, 2015

27. The applicant submitted two neuropsychological treatment plans to the respondent. Each of the two treatment plans, completed by the same provider, was in the amount of $2,200 and dated March 30, 2015.

28. One of the treatment plans was for neuropsychometric testing, while the other was for a neuropsychological assessment.

29. The respondent approved one of the treatment plans and denied the other as they relate to the same examination. The respondent's position is that the service provider has attempted to work around the $2000.00 cap applicable to such assessments by breaking the assessment into two parts in order to maximize the amount that can be charged for the work.

30. The applicant submits that the two assessments are distinct from each other and, each should be afforded its own assessment limit. She argued that a neuropsychological assessment and neuropsychometric testing cannot be completed within the $2,000 cap and that the hourly fees for the work by the psychologist were reasonable. Further the applicant points out that the purpose of the examination was to make a diagnosis.

31. The applicant also argued that the insurer failed to provide medical reasons as required by 38(8) of the Schedule when it denied the neuropsychological testing treatment plan on April 22, 2015.

32. The respondent states that the issue is the cost of examination under 25(5), and it does not involve s.38 (8).

33. It is my view that section 38 does not apply because the reports are the result of one assessment and it was approved by the insurer as one document. In fact nothing was being denied, rather the insurer was only paying out the statutory maximum. So, the reports were properly accepted as relating to one assessment.

34. The cost of examinations test under s. 25. (1) sets out that the insurer shall pay the following expenses incurred by or on behalf of an insured person:

> (5) Despite any other provision of this Regulation, an insurer shall not pay, more than a total of $2,000 in respect of fees and expenses for conducting any one assessment or examination and for preparing reports in connection with it, whether it is conducted at the instance of the insured person or the respondent

35. I find that s. 25 (1) of the Schedule recognizes that a single examination may result in more than one report. Although the provider separated the test into two parts for the purposes of reporting, I find that it is still amounted to one examination or assessment performed by the same provider on the same date resulting in two reports. I find based on the evidence that the applicant failed to meet her evidentiary burden. The monetary limit, $2,000, imposed by the Schedule applies.

Is a medical reason required?

36. I find that section 38 does not apply because it only applies in the case of a denial and, there was no denial here, but a payment in accordance with the limits of the schedule.

ORDER

37. Pursuant to the authority vested in it under the provisions of the Act, the Tribunal finds that the applicant is eligible to receive attendant care benefits that are incurred in accordance with the Assessment of Attendant Care Needs form dated September 24, 2014.

38. The applicant is not entitled to a cost of examination for a neuropsychological assessment in the amount of $2,200.

39. The applicant is not eligible for any interest.

Released: May 18, 2017

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Monica Purdy, Adjudicator