Citation: Allwood v. Primmum Insurance Company, 2025 ONLAT 24-000684/AABS

Licence Appeal Tribunal File Number: 24-000684/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:

Madge Allwood

Applicant

and

Primmum Insurance Company

Respondent

DECISION

ADJUDICATOR: **Tami Cogan**

APPEARANCES:

For the Applicant: Filipe Santos, Counsel

For the Respondent: Eric Grossman, Counsel

HEARD: **In Writing**

OVERVIEW

[1] Madge Allwood, the applicant, was involved in an automobile accident on January 18, 2022, and sought benefits pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010 (including amendments effective June 1, 2016)* (the "*Schedule*"). The applicant was denied benefits by the respondent, Primmum Insurance Company, and applied to the Licence Appeal Tribunal - Automobile Accident Benefits Service (the "Tribunal") for resolution of the dispute.

ISSUES

[2] The issues to be decided are:

1. Is the applicant entitled to a non-earner benefit of $185.00 per week from February 15, 2022 to date?
2. Is the applicant entitled to $2,460.00 for a psychological assessment, proposed by 101 Assessments dated March 1, 2022?
3. Is the applicant entitled to $2,460.00 for a neurological assessment, proposed by 101 Assessments dated June 14, 2022?
4. Is the applicant entitled to interest on any overdue payment of benefits?
5. Is the respondent liable to pay an award under s. 10 of Reg. 664 because it unreasonably withheld or delayed payments to the applicant?

RESULT

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

1. The applicant is not entitled to a non-earner benefit of $185.00 per week from February 15, 2022 to January 16, 2024.
2. The applicant is not entitled to $2,460.00 for a psychological assessment, proposed by 101 Assessments dated March 1, 2022.
3. The applicant is not entitled to $2,460.00 for a neurological assessment, proposed by 101 Assessments dated June 14, 2022.
4. The applicant is not entitled to interest on overdue payment of benefits.
5. The respondent is not liable to pay an award under s. 10 of Reg. 664.

PROCEDURAL ISSUE

Late served medical records

[4] The respondent submits that that applicant served medical records on the respondent two days before the applicant's submissions were due to be filed, which is nearly six months after the production deadlines in the Case Conference Report and Order. The respondent submits the reliance on these medical records is prejudicial to the respondent who has not had an opportunity to seek expert opinion on the records. The respondent seeks relief in that the documents be excluded from the record.

[5] The applicant did not file a reply to the respondent's submissions.

[6] I find that the clinical notes and records of Humber River Hospital from January 18, 2019 to April 3, 2024 will be given little weight because I have not been provided an explanation from the applicant as to why these records could not have been produced in accordance with the Case Conference Report and Order. I find it is prejudicial to the respondent to have evidence presented with only a few days to review and respond. In the result, I find these records are not persuasive evidence in support of the applicant's case for NEB, or the treatment plans in dispute for the reasons that follow.

ANALYSIS

Non-Earner Benefits (NEB)

[7] I find that the applicant has not established that she is entitled to a NEB for the following reasons.

[8] Section 12(1) of the *Schedule* provides that an insurer shall pay an NEB to an insured person who sustains an impairment as a result of the accident, if the insured person suffers a complete inability to carry on a normal life as a result of and within 104-weeks after the accident. Section 3(7)(a) defines a "complete inability to carry on a normal life" as "an impairment that continuously prevents the person from engaging in substantially all of the activities in which the person ordinarily engaged before the accident."

[9] The test for an NEB is set out in the Court of Appeal decision of *Heath v. Economical Mutual Insurance Company* 2009 ONCA 391 ("*Heath*"), which generally focuses on a comparison of the applicant's pre- and post-accident activities, as follows:

i. A comparison between the applicant's activities and life circumstances before and after the accident.

ii. Assessing the applicant's activities and life circumstances requires more than a snapshot in time but involves assessing it over a reasonable period prior to the accident and the duration after is case specific.

iii. In proving "substantially all" requires looking at all the applicant's pre-accident activities and life circumstances but greater emphasis can be placed on the ones that matter the most to the applicant.

iv. "Continuously prevents" means that it's of a nature, extent or degree that is and remains uninterrupted.

v. "Engaging in" refers to a qualitative perspective – going through the motions may not be "engaging in," and if doing the activity is sufficiently restricted then it's not "engaging in".

vi. If pain is a primary factor that prevents the applicant from engaging in their pre-accident activities, the question is not whether the applicant can physically do the acts, but are they practically prevented from engaging in those activities?

[10] The applicant submits that at the time of the accident she was employed as an elementary school teacher. As a result of her shoulder injury, she was off work for 8 - 9 months, before returning to work with limitations on her ability to teach. The applicant asserts that the shoulder injury continuously prevents her from engaging in substantially all of the activities in which she ordinarily engaged before the accident.

[11] I find I am unable to meaningfully analyse whether the applicant's accident-related injuries substantially prevent her from engaging in her pre-accident activities, in accordance with *Heath*, because the applicant has not directed me to evidence of what her pre-accident activities were, with the exception of teaching. I have heard her submission that she is unable to teach in the way that she did before the accident, however, I have no details of what has changed, or how. *Heath* requires an analysis of the applicant's activities and life circumstances to understand what it was that she engaged in pre-accident that she is unable to engage in post-accident. Further, the parties agree that the applicant was working pre-accident and returned to work post-accident.

[12] The respondent submits the applicant would have qualified for Income Replacement Benefits (IRB), which would preclude the entitlement to NEB pursuant to s. 12(3)(d) of the *Schedule*. The applicant has not provided submissions or evidence as to why she does not qualify for IRB considering her employment history or why she elected to pursue NEB.

[13] I find that the applicant has not proven on a balance of probabilities that she has suffered a complete inability to carry on a normal life as a result of and within 104-weeks after the accident, and is therefore not entitled to NEB.

Treatment / Assessment Plans

[14] To receive payment for a treatment and assessment plan under s. 15 and 16 of the *Schedule*, the applicant bears the burden of demonstrating on a balance of probabilities that the benefit is reasonable and necessary as a result of the accident. For an assessment, by their nature, assessments are speculative. They are conducted to determine if an applicant has a specific condition or meets a specific threshold. There is a possibility that the assessment will prove negative. Nonetheless, there must be some evidence that the specified condition exists, and that further investigation is reasonable and necessary.

Psychological Assessment

[15] I find that the applicant has not established that the psychological assessment is reasonable and necessary or payable pursuant to section 38 of the *Schedule*.

[16] I have reviewed the treatment plan for the psychological assessment, completed by Konstatinos Papazoglou, Psychologist, on February 24, 2022. The goals of the plan are identified as an assessment of the applicant's psychological condition and to recommend possible treatment to help her function effectively in her social, occupational, and other important areas of functioning. The plan includes the assessment at a cost of $2,000.00 and the completion of the OCF-18 at a cost of $200.00, plus HST, for a total cost of $2,460.00.

The respondent's denial is compliant with section 38(8)

[17] The applicant submits that the respondent's letter dated March 10, 2022, is not a proper letter of denial, is insufficient and not in accordance with s.38(8) of the *Schedule*, and therefore the applicant is entitled to incur all amounts related to the plan, until such time as the deficiency is cured.

[18] Section 38(8) of the *Schedule* requires an insurer to inform an insured person, within 10 business days after it receives the treatment plan, of the medical and other reasons why it considered the goods and services not to be reasonable and necessary if it denies a plan. Pursuant to s. 38(11), if an insurer fails to comply with its obligations under section 38(8), it must pay for the goods and services that relate to the period starting on the 11th business day after the insurer received the application and ending on the day the insurer gives a notice described in s. 38(8) and it is prohibited from taking the position that the insured person has a impairment to which the MIG applies.

[19] I find that the respondent's letter of March 10, 2022, identifies the service provider, Konstantinos Paoazoglou, and provides the applicant with an explanation, as follows:

> We do not agree to pay for any of the following goods, services and/or assessments for medical reasons and all other reasons known as of the date of this notice as follows:
>
> To date we have not been provided with objective medical evidence to support that you have sustained injuries at the subject motor vehicle accident which would prevent your ability to achieve maximal recovery within the Minor Injury Guideline, nor have we received compelling medical evidence to indicate that you have a preexisting condition which would preclude your recovery within the minor injury framework.
>
> Please be advised that we will not pay for any portion of the approved goods, services and/or assessments that are payable under any other insurance plan.

[20] I do not accept the applicant's submission that the reasons are insufficient or unclear because the applicant suggests that partial sentences, taken out of context are evidence the respondent has not met its obligation under s.38(8). I find the sentences must be read fully in order to understand them, which is reasonable. The applicant further submits that the medical reasons for the denial are inadequate. I find that the respondent is clear that it "[has] not been provided with objective medical evidence". It is the onus of the applicant to provide medical evidence upon which medical reasons can be grounded, without which, reasons cannot be given.

[21] I find the respondent has met its obligation in accordance with s.38(8).

The treatment plan is not reasonable and necessary

[22] I find that the treatment plan is not reasonable and necessary. In this regard, I find the psychological assessment of Dr. Papazoglou less persuasive than that of Dr. Terra Seon, Psychologist, because Dr. Papazoglou's assessment was conducted via telephone, as opposed to in-person. Further, Dr. Papazoglou relies on the subjective reporting from the applicant without review of her medical records. It appears that the psychometric testing was also conducted verbally during the telephone call. Also, Dr. Papazoglou completed the treatment plan recommending the psychological assessment to be completed by himself.

[23] I find the reports of Dr. Seon to be more persuasive because she reviewed the applicant's medical documentation and met with the applicant in person on two occasions. I note the primary complaints of the applicant were physical in nature. I note that during her assessment with Dr. Seon, the applicant reported that her physiotherapist referred her for a psychological assessment. Dr. Seon concluded that the applicant did not sustain a psychological injury or suffer from a psychological condition as a result of the accident, and opined the treatment plan for a psychological assessment was not reasonable or necessary.

[24] It is well established that a treatment plan must be supported by corroborating medical evidence. I have not been directed to corroborating medical records that support the applicant was experiencing psychological symptoms. Although the applicant was attending her family physician on a frequent basis after the accident, there are no references or documentation in the family doctor's clinical notes and records, or elsewhere, of any psychological complaints after the accident, except in the treatment plan itself.

[25] I find on a balance of probabilities the applicant has not proven that the treatment plan for a psychological assessment is reasonable and necessary. Therefore, she is not entitled to this plan.

Neurological Assessment

[26] I find that the applicant has not established that the neurological assessment is reasonable and necessary.

[27] I have reviewed the treatment plan for the neurological assessment completed by Bill Nikols, Chiropractor, on May 10, 2022. The goals of the plan are identified as pain reduction and return to activities of normal living. The cost of the plan is identified as $2,000.00 for the evaluation by Dr. Vince Basile, Neurologist, and $200.00 for the completion of the OCF-18, plus HST, for a total cost of $2,460.00.

The respondent's denial is compliant with s. 38(8)

[28] The applicant submits that the applicant has been complaining of a head injury since the accident, including to her family doctor. She submits that the letter of denial dated June 24, 2022, was insufficient and not in accordance with s.38(8) of the *Schedule*. Also, she submits the respondent's letter of March 10, 2022 does not address the head injury complaints, therefore the applicant is entitled to incur all amounts related to the plan, until such time as the deficiency is cured. The applicant submits that an Insurer's Examination was not arranged following this denial. Also, the applicant subsequently obtained and provided medical records, and the respondent unreasonably refused or failed to adjust the claim.

[29] I find the letters of March 10, 2022, and June 24, 2022, do not address the applicant's head injury complaint, however, the only suggestion of a head injury in the treatment plan is a list of reported symptoms, without supporting independent medical evidence. I have not been directed to evidence that supports any medical records were provided to the respondent until after the June 24, 2022 letter of denial. Also, as stated above at paragraph 15, I do not accept the applicant's submission that the reasons are insufficient or unclear because the applicant suggests that partial sentences, taken out of context, are evidence the respondent has not met its obligation under s.38(8). I find the letter of denial does provide medical reasons, those being a lack of medical evidence, as well as other reasons, those being the funding limit under the Minor Injury Guideline. I find the respondent has met its obligations under s. 38(8).

The treatment plan is not reasonable and necessary

[30] I find the treatment plan for the neurology assessment, completed by a chiropractor, does not refer to a head injury, but rather includes a list of reported symptoms. The treatment plan does not mention a neurology assessment until the end of the appendix, which follows a summary of a psychological assessment. I find that there is a lack of reasoning provided in the recommendation for the assessment, as well as the goals of the treatment plan, are vague and unsupported by corroborating medical evidence.

[31] The applicant submits that on October 20, 2022, Dr. Forbes, the applicant's family doctor, referred her to a neurologist for an assessment with Dr. Pelikan, neurologist, which took place on December 1, 2022. I find that the assessment has been completed by an OHIP funded medical practitioner. Having already been completed the proposed treatment plan is duplicative and not reasonable and necessary.

[32] I find on the applicant has not proven on a balance of probabilities that the neurology assessment is reasonable and necessary.

Interest

[33] As there is no overdue payment of benefits, the applicant is not entitled to interest pursuant to s. 51 of the *Schedule*.

Award

[34] I find the respondent is not liable for an award under s.10 of Reg 664.

[35] The applicant sought an award under s. 10 of Reg. 664. Under s. 10, the Tribunal may grant an award of up to 50 per cent of the total benefits payable if it finds that an insurer unreasonably withheld or delayed the payment of benefits.

[36] The applicant submits that the respondent ignored medical evidence that supports the treatment plans, which has caused distress and has been detrimental to the applicant.

[37] The respondent submits the applicant has not provided evidence that the respondent acted in bad faith and unreasonably withheld benefits.

[38] I find that the respondent has not unreasonably withheld benefits, or acted in a manner that would attract an award because the denials of benefits were proper, for the reasons stated above.

[39] I find the applicant has not proven on a balance of probabilities that she is entitled to an award under s. 10 of Reg 664.

ORDER

[40] For the reasons above, I find the following:

1. The applicant is not entitled to a non-earner benefit.
2. The applicant is not entitled to $2,460.00 for a psychological assessment.
3. The applicant is not entitled to $2,460.00 for a neurological assessment.
4. No interest is owing.
5. The respondent is not liable to pay an award under s. 10 of Reg. 664.

Released: November 27, 2025

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Tami Cogan
Adjudicator