Appeal P15-00007

OFFICE OF THE DIRECTOR OF ARBITRATIONS

CHARMAINE MARIE GREEN

Appellant

and

BELAIR INSURANCE COMPANY INC.

Respondent

BEFORE:	Delegate Richard Feldman
REPRESENTATIVES:	Mr. Alon Rooz for the Appellant, Ms. Charmaine Marie Green Mr. Thomas R. Hughes for the Respondent, Belair Insurance Company Inc.
HEARD:	On the record (including written submissions from the parties)

APPEAL ORDER

Under section 283 of the *Insurance Act*, R.S.O. 1990 c. I.8 as it read immediately before being amended by Schedule 3 to the *Fighting Fraud and Reducing Automobile Insurance Rates Act, 2014*, and Regulation 664, R.R.O. 1990, as amended, it is ordered that:

1. The appeal of the order in Arbitration File No. A11-000765 dated December 18, 2014 is allowed in part. That order is varied as follows:
    a. Paragraphs 2 and 5 of that order are revoked; and
    b. Paragraph 1 is rescinded and is replaced with the following:
        1. Ms. Green is entitled to a medical benefit in the amount of $127.44 for services by Osler Rehabilitation.

2. The following outstanding issues are to be determined by an Arbitrator other than the one who issued the order of December 18, 2014:
    a. whether Ms. Green is entitled to $1,074.74 for the cost of a follow-up in-home assessment recommended by Assessment Direct in an application dated March 2, 2010;
    b. interest on overdue payment of benefits;
    c. entitlement to and quantum of a special award; and
    d. expenses of the arbitration proceeding.

3. If the parties are unable to agree about expenses of this appeal, an expense hearing may be arranged in accordance with Rule 79 of the *Dispute Resolution Practice Code*.

4. The appeal is otherwise dismissed.

November 16, 2016

Richard Feldman
Director's Delegate

Date

REASONS FOR DECISION

Minor errors at Page 8 (Footnote 12) corrected on December 9, 2016 in accordance with the *Dispute Resolution Practice Code* and section 21.1 of the *Statutory Powers Procedure Act.

I. BACKGROUND

On September 20, 2009, the Appellant, Ms. Charmaine Marie Green, was driving a motor vehicle. As she entered a roadway, her vehicle was struck by another vehicle. Ms. Green allegedly sustained impairments as a result of this incident and she applied to the Respondent, Belair Insurance Company Inc. ("Belair"), for statutory accident benefits available under the *1996 Schedule.*[1]

Ms. Green's claims included requests for the cost of extensive treatment by Osler Rehabilitation Centre Inc. ("Osler") and for the cost of numerous assessments by Assessment Direct Inc. ("Assessment Direct"). Eighty-five treatment and assessment plans were submitted to Belair on behalf of Ms. Green between October 2009 and September 2010. Belair paid over $37,000 in expenses to Osler alone within the first eight months following the September 2009 incident.

Disputes arose between the parties concerning Ms. Green's entitlement to certain accident benefits and in March 2011, Ms. Green commenced arbitration proceedings (File No. A11-000765) at the Financial Services Commission of Ontario ("FSCO").

By about May 2010, Belair became suspicious because of the sheer volume of plans that were being submitted by Osler and Assessment Direct (not just in this case but in a great number of cases involving many insured persons) and Belair began to refuse to pay for goods and services recommended by these companies. In June 2011, Belair and related insurance companies[2] commenced an action (Court File No. CV-11-428030) in the Ontario Superior Court of Justice

[1] *The Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996, Ontario Regulation 403/96,* as amended.

[2] Intact Insurance Company, the Nordic Insurance Company of Canada and Trafalgar Insurance Company of Canada.

seeking millions of dollars in damages against Assessment Direct, Osler and others. Amongst other things, the plaintiffs in that action allege that the defendants conspired to unjustly enrich themselves by making material misrepresentations to the plaintiffs, by submitting claims for services that were not reasonably required by insured persons, by submitting invoices for goods and services that were not actually provided and by seeking to "flood" the plaintiffs with such a large volume of claims that they would be incapable of responding within the statutorily-mandated time period(s), thus unfairly leaving the plaintiffs liable to pay for goods and services that were never actually required and/or provided.

The plaintiffs in that action then brought motions in arbitration proceedings that were pending at FSCO (including that of Ms. Green), seeking a stay of those arbitration proceedings until after the determination of the court action. I heard and denied that motion in early 2012.[3] My decision was upheld on appeal.[4]

As a result, Ms. Green's application for arbitration proceeded to a hearing. It was heard by Arbitrator Lloyd (J.R.) Richards (the "Arbitrator") in December 2013 (with written submissions in January 2014).

In that proceeding, Ms. Green claimed the following:

1. $11,886.04 for various unpaid medical/rehabilitation benefits provided (allegedly) by Osler;
2. $1,074.74 for the cost of a follow-up in-home assessment by Dr. Shteynberg;[5]
3. $814.63 per month (less amounts paid) in attendant care benefits from September 20, 2009 through September 19, 2011;
4. $100.00 per week (less amounts paid) in housekeeping and home maintenance benefits from September 20, 2009 through September 19, 2011;

[3] *Green and Belair Insurance Company Inc.* (FSCO A11-000765, March 19, 2012).

[4] *Intact Insurance Company et al. and Aweys et al.* (FSCO P12-00007 – P12-00021, February 1, 2013).

[5] This assessment was recommended in a plan from Assessment Direct dated March 2, 2010 and was performed (allegedly) on August 16, 2010 (according to a report from Dr. Shteynberg dated August 18, 2010).

5. Interest on overdue payment of benefits;
6. A special award (due to the unreasonable withholding of benefits by Belair); and
7. Her expenses of the arbitration proceeding.[6]

In a decision issued on December 18, 2014, the Arbitrator dismissed all of Ms. Green's claims. Although I will discuss some of his reasons in greater detail below, in general, the Arbitrator dismissed Ms. Green's claims because:

- He found Ms. Green not to be a credible witness and found that she failed to prove, on a balance of probabilities, the exact impairments that she sustained as a result of the September 20, 2009 incident and that such impairments, if any, were either as severe or as long-lasting as she claimed;
- He found that none of the treatments claimed on Ms. Green's behalf by Osler were reasonable and necessary;
- He gave no weight to any documents from either Osler or Assessment Direct and drew a negative inference from the failure of Ms. Green to call any medical practitioner from either company as a witness at the hearing;
- With respect to the claim for medical/rehabilitation benefits, he found that Ms. Green had failed to prove that the goods and services in question were *provided* by Osler and, therefore, he found that such expenses are not payable by Belair;
- With respect to the follow-up in-home assessment by Dr. Shteynberg, he dismissed this claim on the basis that Ms. Green failed to prove that the assessment was reasonable and necessary or that it had actually been done;
- With respect to her claim for attendant care benefits and housekeeping and home maintenance benefits, in addition to other concerns the Arbitrator had with respect to Ms. Green's credibility, he also drew a negative inference from the failure of Ms. Green to have the alleged service provider (her son) testify at the hearing.

[6]Belair also sought its expenses of the arbitration proceeding.

II. NATURE OF THE APPEAL

In this appeal, Ms. Green does not challenge the dismissal of her claims for attendant care benefits, housekeeping and home maintenance benefits or the cost of *treatment* at Osler. The Appellant recognizes that, pursuant to subsection 283(1) of the *Insurance Act*, I have no jurisdiction to consider questions of fact and that this appeal must be restricted to questions of law. The Appellant claims, however, that the Arbitrator did err in law in dismissing her claim for the following:

1. With respect to any treatment plan that was approved by Belair or that Belair failed to respond to within the ten business days (i.e., plans that are "deemed approved"):
    a. the costs associated with Osler performing any *assessment* necessary to complete the treatment plan (a total of $700.00);[7] and
    b. the costs associated with the completion of each treatment plan (a total of $643.48);[8]
2. $1,074.74 for the cost of a follow-up in-home assessment by Dr. Shteynberg;
3. Interest on any benefits that are found to be owing to Ms. Green; and
4. A special award based upon any benefits that are found to be owing to Ms. Green.

III. SCOPE OF THE APPEAL

At the arbitration hearing (in her closing arguments), Ms. Green advanced several alternative arguments concerning the outstanding invoices from Osler, including the following:

- She argued that the goods and services in question were reasonable and necessary; and
- In the alternative, with respect to goods and services that were either approved or for which the Insurer did not provide a notice under subsection 38(8) of the *Schedule*

[7] A total of $700.00 for assessments related to the completion of four treatment plans.

[8] A total of $643.48 comprised of: $70.00 for completing one plan submitted through the Health Claims for Auto Insurance ("HCAI") system and $63.72 each for completing nine others (sent by fax, not through HCAI).

> (i.e., where the plan was "deemed approved" because the Insurer failed to challenge all or part of the treatment plan), pursuant to paragraph 2 of subsection 38(8.2) of the *Schedule*, the Insurer "shall pay for all goods and services provided under the treatment plan…" and that, pursuant to the *Professional Service Guidelines 01/09* (July 2009), this includes the expenses related to any assessments necessary to complete a plan and related to preparation of the plan itself [9].

With respect to the disputed cost of the follow-up in-home assessment, Ms. Green simply repeated these same alternative arguments that, either it was reasonable and necessary (and was incurred) or, in the alternative, pursuant to paragraph 38(8.2)2 of the *Schedule*, the Insurer must pay the cost of this assessment because it failed to respond to the plan within the time permitted. These arguments concerning the effect of paragraph 38(8.2)2 of the *Schedule* were repeated in the Appellant's written submissions (March 2015) in this appeal.

In addition, in the Appellant's reply submissions (April 2015) and amended reply submissions (June 2015), the Appellant also relies upon subsection 38.2(9) of the *Schedule* in support of her claim for the cost of the disputed in-home assessment of August 2010.

Subsection 38.2(9) provides that if an insurer does not refuse an application for an assessment (due to a conflict of interest) and fails to give the notice as required under subsection 38.2(6) (stating, amongst other things, what the insurer agrees to pay for and whether the insurer requires the insured person to submit to an insurer's examination under s. 42), the insurer "shall pay for all assessments and examinations to which the application relates."

This appeal was supposed to be heard on April 7, 2016. At the outset of that hearing, the parties agreed as to the scope of this appeal.[10] When the Appellant began to make arguments based

[9] up to $63.72 for forms sent in paper form or up to $70.00 for forms submitted through HCAI.

[10] See the last paragraph on p. 5 of the interim decision of Delegate Blackman, issued on April 19, 2016: "I summarized that this concerns $2,417.22 ($1,074.74 for the follow-up Home Assessment and $1,342.48 for the Osler Treatment Plans) plus interest and a special award that flowed therefrom, and the meaning of paragraph 38(8.2)(2) of the 1996 *Schedule*. The Respondent agreed with that summary of the issues."

upon subsection 38.2(9) of the *Schedule*, however, Delegate Blackman queried whether this paragraph had been previously raised by the Appellant. According to the interim appeal decision of Delegate Blackman in this matter (dated April 19, 2016), Mr. Rooz agreed that subsection 38.2(9) had not been raised at the original arbitration hearing and had not been raised in the Appellant's written submissions on this appeal.[11]

The appeal hearing was adjourned so that the parties could make written submissions on what appeared to be an attempt by the Appellant to add a new ground of appeal and the parties were advised that, since Delegate Blackman was retiring, a determination of that issue and a new hearing date would be set once a new Director's Delegate was appointed to decide this appeal. As a result of this last-minute adjournment caused by the Appellant, Delegate Blackman ordered the Appellant to pay to the Respondent $750.00 for the Respondent's "costs thrown away".

I assumed carriage of this appeal in July 2016. On September 20, 2016, I conducted a telephone case conference with counsel for both parties. During this case conference, the parties consented to have all outstanding issues that have been raised in this appeal[12] decided by me upon the record, without any further submissions from the parties.

With respect to the issue of whether the Appellant is entitled in this appeal to rely upon subsection 38.2(9) of the *Schedule*, I find in favour of the Appellant. Although counsel for Ms. Green did not specifically refer to this subsection in the closing written submissions at the original arbitration hearing, Ms. Green was generally taking the position that Belair was obliged to pay the cost of both treatments and assessments/examinations where Belair either approved of same or failed to provide the notice required by the *Schedule* within the mandated time limit (i.e. where the treatment plan or proposed assessment/examination had been "deemed approved"). As a member of an expert tribunal specializing in adjudicating disputes over no-fault accident

[11]Mr. Rooz may have misdirected himself and Delegate Blackman on this point, however, since the Appellant's written submissions in this of April and June 2015 do make reference to subsection 38.2(9) of the *Schedule*, although not specifically in relation to the cost of the disputed follow-up in-home assessment.

[12]i.e., the issue of whether the Appellant is entitled in this appeal to rely upon subsection 38.2(9) of the *Schedule* and the determination of the merits of the appeal.

benefits, the Arbitrator is deemed to have been aware of the relevant regulatory provisions applicable in this case and I find that the failure of Ms. Green to specifically cite subsection 38.2(9) of the *Schedule* at the original hearing is not fatal to her ability to rely upon that provision.

Furthermore, Ms. Green's counsel did specifically refer to subsection 38.2(9) in her written submissions in this appeal in April and June 2015, well before the commencement of the hearing in April 2016. Belair cannot reasonably argue that it was taken by surprise or has suffered prejudice that cannot be remedied by an award of legal expenses as a result of the Appellant now specifically relying upon this provision in relation to her claim for the cost of the disputed follow-up in-home assessment. To permit the Appellant to rely upon paragraph 38.2(9) of the *Schedule* does not, in this case, require an extension of the time in which to file an appeal. The appeal was filed in time and the Appellant specifically cited this paragraph as one of the grounds for this appeal (without objection from the Respondent) about one year prior to the commencement of the appeal hearing.

I note, however, that the revised Notice of Appeal filed by the Appellant on May 22, 2016 purports to include new claims (an additional $3,494.26) related to treatment plans dated July 12, August 3, 11 and 20, 2010. The Appellant, on April 7, 2016, confirmed the scope of this appeal to the presiding Director's Delegate. The Appellant did not seek leave to amend its Notice of Appeal. Rather, at most, the Appellant was signaling on April 7, 2016 that she was seeking to rely upon a further ground of appeal that may not have been fully fleshed-out in her written submissions. The attempt by the Appellant on page 2 of her revised Notice of Appeal (dated May 22, 2016) to expand the scope of this appeal was not pursuant to any order from a Director's Delegate and was not responsive to the directions of Delegate Blackman.[13] Delegate Blackman was simply permitting the Appellant to make written submissions as to why the Appellant should be permitted in this appeal to rely upon subsection 38.2(9) of the *Schedule* and to explain the substance of this "new" ground of appeal.

[13]Delegate Blackman's directions are found at page 7 of his decision dated April 19, 2016.

While I am prepared to permit the Appellant to rely upon subsection 38.2(9) in relation to the disputed in-home assessment, I will not permit the Appellant to expand, at this late stage, the scope of the appeal. In any event, for reasons that shall become obvious later in this decision, even if I had permitted the Appellant to add these additional claims to this appeal, the appeal related to these claims must fail for the same reasons that I am denying the Appellant's claims concerning all "deemed approved" treatment plans (which will be discussed in detail, below).

IV. ANALYSIS

Cost of Preparing a Treatment Plan

(a) Cost of Completing the Plan

Pursuant to paragraph 24(1)4 of the *Schedule*, an insurer shall pay reasonable fees charged by a health practitioner for reviewing a treatment plan under section 38, and for approving it if appropriate. Pursuant to Superintendent's Guideline No. 01/09 (Professional Services Guideline), at the relevant time, the maximum amount payable for completion of a treatment plan (Form OCF-18) was $63.72 for a paper version or $70.00 for the HCAI electronic version. The Appellant alleges that the Arbitrator erred in law in not awarding to Ms. Green the cost of having health practitioners from Osler prepare various treatment plans that were either approved or that ought to be "deemed approved".

The details for plans from Osler that were *approved* by Belair and that are supported by documents filed at the arbitration hearing on behalf of the Appellant are as follows:

DATE OF PLAN (MM/DD/YYYY)	COST OF PROPOSED GOODS AND SERVICES ($)	ADDITIONAL AMOUNT SUBSEQUENTLY INVOICED FOR FORM PREPARATION ($)	DATE OF INVOICE FOR FORM PREPARATION FEE (MM/DD/YYYY)
10/09/2009	1,299.11	63.72[14]	10/15/2009
11/25/2009	972.62	nil[15]	n/a
04/30/2010	304.90	63.72	05/14/2010
05/28/2010	869.75	nil[16]	n/a
		Total $127.44	

Belair has not disputed that it approved and paid these four treatment plans and that it has not paid any fee for preparation of these plans. The invoices from Osler, however, only show that $127.44 was actually invoiced to Belair in relation to the cost of completion of two of the four treatment plans referenced by the Appellant. Despite the finding of the Arbitrator that the Applicant had not proven that the goods and services recommended in the various treatment plans from Osler were actually *provided* to Ms. Green, there can be no question that the treatment plans listed above were actually completed and delivered to Belair. To the extent that Belair approved and paid for the goods and services proposed in these plans, Belair is also required to pay for the preparation of these plans (if actually invoiced for same). Based upon the

[14]The Appellant is claiming an additional $63.72 (i.e., a total of $127.44) for the cost of completion of this treatment plan. According to the "Account Activity" records from Osler and the Invoice from Osler dated October 15, 2009 (part of Exhibit 31), there was an additional $63.72 charged in relation to completion of a Form OCF-22 on October 6, 2009, but the Appellant has made no claim in relation to completion of an OCF-22 Form dated October 6, 2009. No witnesses were called from Osler to explain anything about the goods and services Osler recommended and/or provided or their billings related to same.

[15]The Appellant is claiming $63.72 for the cost of completion of this treatment plan but the actual invoice from Osler covering this period shows no such fee related to a plan dated November 25, 2009. It does show a fee of $63.72 for completion of a Form OCF-22 dated November 19, 2009 but the Appellant has made no claim in relation to completion of an OCF-22 Form dated November 19, 2009.

[16]The Appellant is claiming $70.00 for the cost of completion of this treatment plan but the actual invoice from Osler covering this period shows no such fee related to a plan dated May 28, 2010. It does show a fee of $70.00 for completion of a Form OCF-22 dated May 21, 2010 but the Appellant has made no claim in relation to completion of an OCF-22 Form dated May 21, 2010.

record, Belair was invoiced a total of $127.44 in relation to two of the four treatment plans listed above and it is undisputed that Belair failed to pay this sum.

The Appellant submits that the Arbitrator erred in law in failing to consider in his decision Belair's obligation to pay for the cost of preparing plans that were approved by Belair. I agree. With respect to these form-preparation expenses, once Belair approved the plans, it was no longer necessary for the Appellant to prove that the goods and services recommended in the treatment plans were reasonable and necessary.[17] Consequently, Belair must pay $127.44 in connection with these expenses (plus interest due under the *Schedule*). I shall make the necessary order to correct this minor error.

I appreciate Belair's contention that Osler sought to take advantage of weaknesses within the no-fault benefits system to unjustly enrich itself. Nothing in this current appeal is meant to deprive Belair of its right, in its civil action, to seek compensation for damages that Belair can prove it sustained as a result of any wrongful conduct on the part of Osler or its principals.

With respect to the cost of preparing treatment plans that the Appellant claims were "deemed approved", the details are as follows:

DATE OF PLAN (MM/DD/YYYY)	**COST OF PROPOSED GOODS AND SERVICES ($)**	**ADDITIONAL AMOUNT SUBSEQUENTLY INVOICED FOR FORM PREPARATION ($)**	**DATE OF INVOICE FOR FORM PREPARATION FEE (MM/DD/YYYY)**
10/23/2009	1,092.25	63.72	10/29/2009
11/12/2009	972.47	63.72	11/25/2009
11/30/2009	961.82	63.72	12/31/2009
12/23/2009	946.02	63.72	12/31/2009
01/13/2010	919.23	63.72	01/29/2010
		Total $318.60	

[17] See *Halim and Security National Insurance Co./Monnex Insurance Mgmt. Inc.*, (FSCO P07-00035, August 8, 2008) for a similar conclusion from Delegate Blackman in analogous circumstances.

The Appellant submits that, with respect to treatment for which the Insurer did not provide a notice under subsection 38(8) of the *Schedule* (i.e., where the plan was "deemed approved" because the Insurer failed to challenge all or part of the treatment plan), pursuant to paragraph 2 of subsection 38(8.2) of the *Schedule*, the Insurer "shall pay for all goods and services provided under the treatment plan…" and that, pursuant to the *Professional Service Guidelines 01/09* (July 2009), this includes the expenses related to preparation of the plan itself.

It is undisputed that Belair failed to provide a notice under subsection 38(8) with respect to any of the five treatment plans listed in the table above. The Appellant therefore argues that it was an error for the Arbitrator not to order that Belair pay $63.72 for the cost of completion of each of these "deemed approved" treatment plans (a total of $318.60).

Paragraph 38(8.2)2 of the *Schedule* provides that where an insurer fails to give a notice under subsection 38(8), the insurer "shall pay for all goods and services provided under the treatment plan that relate to the period starting on the 11th business day after the day the insurer received the application and ending on the day the insurer gives the notice in paragraph 1 of subsection (8)."

The Appellant focuses only on the first few words of this paragraph ("shall pay for all goods and services") and ignores the rest. When one considers the entire paragraph, however, it is obvious that the Appellant's argument fails for two reasons. First, the cost of completing the treatment plan is not a service "provided *under* the treatment plan" (emphasis added). Second, the cost of completing a plan is also not a service related to the period starting on the 11th business day after the day the insurer received" the plan. Obviously, completion of the plan occurs prior to delivery of the plan. Paragraph 38(8.2)2 was meant to ensure that, where an insurer does not respond to a treatment plan, the insured person, starting 11 business days after delivery of the plan, can begin to obtain the goods and services that he or she requires, confident that the insurer will have to

pay for same.[18] For both reasons, the Appellant's claim related to the cost of preparing these five plans fails.

Had I permitted the Appellant to amend this appeal by claiming an additional $3,494.26 related to treatment plans dated July 12, August 3, 11 and 20, 2010, these additional claims would also have failed for similar reasons. Any appeal concerning the cost of goods and services recommended in these plans must be dismissed due to the finding of fact made by the Arbitrator that Ms. Green failed to prove that any of the goods or services proposed by Osler was actually *provided*. With respect to the cost of preparing those treatment plans, the Appellant cannot rely upon paragraph 38(8.2)2 of the *Schedule* because, in each case, the service (completion of the treatment plan form) was provided earlier than the 11th business day after delivery of the treatment plan in question.

(b) Cost of Assessment Necessary to Complete the Plan

Under section 24 of the *Schedule*, in most cases, a health practitioner must seek approval before conducting an examination or assessment (for the insurer to be liable to pay for same). Pursuant to paragraph 24(1)11, however, an insurer is required to pay reasonable fees for an assessment or examination reasonably required in connection with the preparation of a treatment plan if:

1. the insurer approved the expense; or,
2. even if prior approval was not obtained from the insurer, the conditions set out in paragraph 24(1.2)1 have been satisfied.

Paragraph 24(1.2)1 states that prior approval of an insurer is not required where:

> An assessment or examination for the purposes of preparing a treatment plan under section 38 in circumstances in which an immediate risk of harm to the insured person or a person in the insured person's care makes obtaining the prior approval of the insurer impractical.

[18] Of course, in this case, this paragraph did not assist Ms. Green in obtaining an order for the cost of goods and services proposed in these plans because she failed to prove that the services were *provided* (which is a requirement of this provision): *Perth Insurance Company and Shmuel* (FSCO P13-00026, July 22, 2014).

In this appeal, the Appellant is claiming the following fees related to assessments she claims were necessary in order for Osler to prepare treatment plans:

DATE OF PLAN (MM/DD/YYYY)	COST OF PROPOSED GOODS AND SERVICES ($)	ADDITIONAL AMOUNT SUBSEQUENTLY INVOICED FOR ASSESSMENT ($)	DATE OF INVOICE FOR ASSESSMENT FEE (MM/DD/YYYY)
10/28/2009	992.37	150.00	10/29/2009
11/30/2009	961.82	150.00	12/31/2009
12/23/2009	946.02	200.00	12/31/2009
05/28/2010	860.75	200.00	06/04/2010
		Total $700.00	

With respect to the plan of May 28, 2010, the Appellant argues that it was approved by Belair. Belair only approved, however, the $860.75 that was requested. The plan itself did not include a claim for $200.00 for an assessment and that amount was never approved by Belair.

With respect to the other three plans listed in the table above, none of them included any amount for an assessment either. The Insurer failed to respond to the plans dated October 28, November 30 and December 23, 2009 and the Appellant argues that, as a result, these plans are "deemed approved".

The Appellant cannot rely on paragraph 38(8.2)2 of the *Schedule* because, once again, the cost of an assessment done in order to complete a treatment plan (and that is not included in the plan itself) is not a service "under the treatment plan" and it is also not a service that relates "to the period starting on the 11th business day after the day the insurer received" the plan.

The Appellant also cannot rely on subsection 38.2(9) of the *Schedule* since there was no plan submitted in advance for the cost of these assessments.

The Appellant might nevertheless be entitled to the cost of these assessments under section 24 of the *Schedule* if she proved at arbitration that:

1. the assessments in question were "reasonably required" in connection with preparation of the treatment plans; and
2. obtaining prior approval by the insurer was impractical due to an immediate risk of harm to the insured person or a person in the insured person's care.

No evidence was adduced at the hearing to support any such findings. I therefore find no error in the Arbitrator's dismissal of these claims.

Cost of Follow-Up In-Home Assessment

(a) Introduction

The Appellant applied to Belair for the cost ($1,074.74[19]) of a follow-up in-home assessment pursuant to an application (Form OCF-22) dated March 2, 2010 (signed by Dr. Frydman of Assessment Direct) in connection with her claim for housekeeping and home maintenance benefits. Belair never responded to the application it received in March 2010 for the cost of the follow-up in-home assessment.[20] The assessment allegedly took place on August 16, 2010 by Dr. Shteynberg and he prepared a report based on this assessment dated August 18, 2010. Assessment Direct invoiced this amount to Belair on or about August 20, 2010 (see Exhibit 23).

According to the record, around February 2010, Belair began denying claims from Ms. Green related to attendant care and housekeeping benefits on the basis that she repeatedly failed to submit to an insurer's examination by an occupational therapist. She finally submitted to such an examination (by Rod Pritchett, O.T.) in June 2010. In a report dated July 2, 2010, Mr. Pritchett recommended 7.25 hours per week of assistance with housekeeping and home maintenance.

[19] $998.65 plus tax.

[20] *Green and Belair Insurance Company Inc.*, (FSCO A11-000765, December 18, 2014), at p. 11.

He also recommended that a follow-up assessment be done in about six to eight weeks (i.e., in mid- to late-August).

On August 16, 2010, Dr. Shteynberg allegedly conducted an assessment of Ms. Green and recommended 5 hours per week of assistance with housekeeping and home maintenance.

The Arbitrator disallowed the cost of Dr. Shteynberg's assessment and report for the following reasons (at p. 12 of the decision):

> First, I find that the assessment was not reasonable and necessary because Ms. Green was not as impaired as she presented to assessors.
>
> Second, in giving evidence, Ms. Green stated that two assessors went to her home. The reports of at least three assessors are in evidence, all of whom claim to have visited Ms. Green at home. The Osler invoice in evidence at this hearing [Ex. 17] also shows that Ms. Green received over two hours of treatment on the date this assessment ostensibly took place (even though Ms. Green gave evidence that she never attended for treatment for over one hour on any given day). Osler is located some distance away from Ms. Green's residence. According to the evidence, Ms. Green would have had to leave her home, go to Osler for 2½ hours of treatment, then go back home to have over 2 hours of assessments. Given the impairments Ms. Green claims, this is implausible. In addition, she has no clear memory of the assessment and she did not call the assessor to confirm that he actually conducted this assessment.
>
> I find that Ms. Green has not proved that this assessment was reasonable, necessary or incurred.

(b) Reasonableness of Assessment

The Appellant argues that she need not prove that the assessment in question was reasonable. The Appellant submits that since Belair failed to respond to the application for approval of an assessment or examination (Form OCF-22) dated March 2, 2010 (a fact that is not denied by Belair), by operation of subsection 38.2(9) of the *Schedule*, Belair must "pay for all assessments and examinations to which the application relates."

The Respondent argues that, pursuant to paragraph 24(1)11 of the *Schedule*, it is only obliged to pay for expenses incurred by or on behalf of an insured for conducting an assessment or

examination and preparing a report if the assessment or examination is reasonably required in connection with a benefit that is claimed. To hold otherwise, it is submitted, would fly in the face of the Court of Appeal's decision in *Stranges*.[21]

In *Stranges*, the Court held that an inadequate refusal notice from an insurer did not automatically entitle the insured person to payment of income replacement benefits in perpetuity.[22] To succeed on her claim for income replacement benefits, Ms. Stranges was still required to prove her claim through evidence of the requisite level of disability.

On this issue, I find in favour of the Appellant. For consumer protection, subsection 38.2(9) of the *Schedule* must be given its plain meaning. It is difficult to fault the Arbitrator for failing to consider subsection 38.2(9) when this provision was not specifically pleaded by counsel for Ms. Green. Nevertheless, he ought to have considered the consequence under the *Schedule* of Belair's failure to respond to the March 2, 2010 application.

If an insurer fails to object to an application for an assessment, an insured person should be able to rely upon the provisions of subsection 38.2(9) of the *Schedule* and proceed to obtain the assessment that has been recommended by medical practitioners with confidence that the insurer will have to pay for same. If an insurer wishes to challenge whether the requested assessment is reasonably required in connection with a benefit claimed, the insurer has the right to insist upon its own assessment under section 42. If the insurer fails to exercise this right, it should not later (after the relevant expense has been incurred) be able to challenge the reasonableness of the insured person having incurred that expense.

To hold otherwise would be to deprive subsection 38.2(9) of any purpose and would be to "eviscerate the intent of subsection 38.2(6)."[23] I also find that the reasoning in *Stranges* is not

[21] *Stranges v. Allstate Insurance Co. of Canada*, 2010 ONCA 457 (CanLII).

[22] i.e., until proper notice was given or a DAC was arranged.

[23] See *Halim and Security National Insurance Co./Monnex Insurance Mgmt. Inc.* (FSCO P07-00035, August 8, 2008), at p. 7. Although this case deals with an earlier version of s. 38.2 of the *Schedule* (when DAC assessments were still available), I find that the reasoning remains relevant and persuasive.

applicable in this case. *Stranges* dealt with the issue of whether a defective refusal from an insurer would automatically obligate an insurer to pay ongoing weekly benefits to an insured person in perpetuity. That is quite different than the effect of an insurer's failure to deliver a notice under s. 38.2(6) of the *Schedule* on its obligation (pursuant to subsection 38.2(9)) to pay a medical professional for a particular assessment and report that is incurred after the time has expired for the insurer to object to the insured person proceeding with the proposed assessment. This is not the case of an insured person receiving a potentially limitless windfall as a result of some technical breach by an insurer.

By focusing on the reasonableness of this assessment, the Arbitrator misdirected himself and erred in law. It is impossible to know to what extent this influenced his finding with respect to the issue of whether these expenses were incurred. This error in law, on its own, is sufficient to justify setting aside the Arbitrator's decision with respect to the expenses related to this assessment.

(c) Whether these Expenses Were Incurred

Pursuant to subsection 38.2(13.5) of the *Schedule*, within 30 days after receiving an invoice for the cost of an assessment or examination, an insurer is obliged to pay for the assessment and examination that it has agreed to pay or that it is required to pay by operation of the provisions of section 38.2. It is self-evident that an invoice ought to be sent to an insurer only *after* the assessment or examination has taken place and any report has been prepared (i.e., where the expenses identified in the application for approval, Form OCF-22, have been *incurred*). That the expense must be *incurred* is both a reasonable interpretation of section 38.2 and is explicitly required by section 24.

The Appellant argues that the Arbitrator erred in concluding that the expenses related to Dr. Shteynberg's assessment of August 16, 2010 and his report of August 18, 2010, were not incurred. In this case, it is submitted, there was no direct evidence that the August 16, 2010

follow-up in-home assessment did not take place. The Arbitrator came to this conclusion based upon certain inferences that he made.

The Respondent submits that this is a finding of fact and, as such, is outside of my jurisdiction to review on this appeal. The Appellant argues that there was no evidence before the Arbitrator upon which this inference could be based and, as a result, this constitutes an error of law.

The Respondent correctly points that an error of fact becomes an error in law where, on appeal, it is determined that the trier of fact made a palpable and overriding error in coming to a factual conclusion.[24] Errors of law include findings of fact made in a complete absence of supporting evidence, made on the basis of conjecture, or made on a misapprehension of the evidence caused by a misdirection on a legal principle.[25] A finding of fact that is based upon factual inferences will generally not be interfered with where evidence exists which supports the conclusion.

The Respondent submits that there were facts before the Arbitrator that supported his conclusion that the assessment did not take place on August 16, 2010 and that the Arbitrator, in coming to this conclusion, was entitled to draw a negative inference from the failure of Ms. Green to produce Dr. Shteynberg as a witness.

So what was the evidence concerning this issue?

Ms. Green testified that she did recall Dr. Shteynberg coming to her home in connection with an assessment.[26] She also testified that she underwent two in-home assessments **in 2009**;[27] she did not state that the in-home assessments in 2009 were the only in-home assessments.

[24]*Housen v. Nikolaisen*, 2002 SCC 33 (CanLII) at p. 253.

[25]*Lombardi and State Farm Mutual Insurance Company*, (FSCO P01-00022, February 26, 2003).

[26]Page 88 of the transcript.

[27]Page 158 of the transcript.

Shelagh Brown, a unit manager at Intact, testified on behalf of the Respondent. She was not, however, the adjuster who handled this file. During her examination-in-chief, Ms. Brown raised a concern over the August 16, 2010 assessment.[28] She indicated that, on August 16, 2010, Osler had billed for approximately two hours of treatment and, based on the amount invoiced by Assessment Direct, the in-home assessment on that date also took about two hours to complete.[29] Ms. Green would have had to have travelled from her home to Osler and then returned home for the assessment.[30] Ms. Brown testified that, to her, "It seemed like a lot in one day."[31] At no time prior to Ms. Brown's testimony did the Respondent ever advise Ms. Green that it was challenging that this assessment had taken place. Ms. Brown did not actually allege that it did not occur; she merely indicated that the Respondent had "concerns".

In short, Ms. Brown or others who work for the Respondent speculated that, while it was possible, it seemed to them unlikely that Ms. Green received two hours of treatment at Osler and underwent an assessment for 1.5 to 2 hours on the same day (August 16, 2010). This conjecture was later adopted by the Arbitrator.

I find that this was not an inference that could reasonably have been based upon the evidence that was before the Arbitrator. Ms. Green testified that Dr. Shteynberg attended at her home.[32] Dr. Shteynberg prepared a report two days later and sent it to Belair. Assessment Direct invoiced Belair for the assessment and the report.

Since Belair never specifically alleged, prior to the hearing, that this assessment did not occur, I find that the Arbitrator was not entitled to draw a negative inference, with respect to whether this expense was incurred, from the failure of Ms. Green to call Dr. Shteynberg as a witness.

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[28]Pages 351-356 of the transcript.

[29]Actually, the assessment took about 1.5 hours. The other half-hour was for education/counselling.

[30]Ms. Brown assumed that treatment was received first and then the assessment was completed. It is not clear how she came to this conclusion (which seems to have been adopted by the Arbitrator).

[31]Transcript, page 356, lines 5 and 6.

[32]There was no evidence adduced as to which came first on August 16, 2010, the treatment or the assessment.

The Arbitrator decided to give no weight to the contents of Dr. Shteynberg's report[33] and he was entitled to do so. Giving no weight to the opinion of Dr. Shteynberg, however, is quite different from concluding that the assessment did not take place at all.

Also, the issue before the Arbitrator was not simply whether the Applicant had proven that the assessment took place on August 16, 2010; the issue was whether the expenses were incurred. The expenses included the cost of reviewing documents, travelling, conducting an assessment, providing education/counselling and preparing a report. Clearly the report in question was produced. Part of the expenses invoiced to Belair were for preparation of this report by Dr. Shteynberg. The Arbitrator fails to explicitly deal with any of the services that were invoiced (like preparation of a report) other than the assessment itself.

To say that the expenses related to this report were not incurred is tantamount to saying that Assessment Direct and/or Dr. Shteynberg created a false document in order to defraud Belair and, therefore, they ought not to be paid for the report (or the assessment that never really took place). Belair had suspicions concerning these expenses, but no real evidence. Furthermore, it is worth noting that, in his report, Dr. Shteynberg actually recommends significantly *less* housekeeping assistance than had been recommended about six weeks earlier by the Insurer's expert. Recommending that Belair pay less seems to me to be inconsistent with an attempt by Dr. Shteynberg or Assessment Direct to defraud the Insurer.

The Arbitrator concluded that the expenses related to the follow-up in-home assessment had not been incurred. This finding was based on mere speculation and was restricted to the question of whether the Applicant proved that the assessment was conducted on August 16, 2010, a narrower question than the one that was before him. His conclusion that the assessment had not been done was based upon inferences that could not be reached upon the evidence. I therefore find that the Arbitrator also erred in law with respect to this finding.

[33]The Arbitrator does make reference to the findings of Dr. Shteynberg (at page 9 of the decision), but he does not rely upon those findings.

I am not, however, entitled to make findings of fact. Thus, I cannot make a determination on this appeal as to whether the expenses identified in the application for approval, Form OCF-22, have been incurred. This issue will have to be determined by an arbitrator.

V. CONCLUSION

In this case, there was certainly the appearance of excessive recommendations for treatment and assessments and little doubt that the Arbitrator was shocked by the sheer magnitude of the plans and invoices that originated from Osler and Assessment Direct. The Arbitrator may also have been influenced by the fact that both civil and other proceedings were pending against these companies at the time that this arbitration came to a hearing. In addition, the Applicant was found not to be a credible witness and the Arbitrator drew a negative inference from her failure to produce any witnesses to corroborate the essential elements of her claims. The Arbitrator found it impossible to believe that Ms. Green sustained the significant impairments she claimed or that she participated in all of the treatment sessions and assessments that were being billed to Belair, yet could produce not a single document to prove that she ever advised her family doctor or any of the numerous medical specialists (who were treating her for significant health issues unrelated to the incident of September 20, 2009) that she had been involved in a car accident in 2009. In light of all this, it is really unsurprising that the Applicant's claims were dismissed.

Nevertheless, Ms. Green advanced arguments to the effect that, under the provisions of the *Schedule*, Belair is required to pay *some* of the expenses she claimed regardless of the Arbitrator's assessment of her credibility or of the reasonableness of the goods and services that had been recommended. The Arbitrator failed to adequately consider these arguments and, to that extent, I have found that his decision contains reversible errors in law. Also, with respect to the cost of the follow-up in-home assessment, the Arbitrator erred in law by making findings that were based upon inferences that were unsupported by any evidence.

For the reasons set out above, this appeal is allowed, in part.

The Arbitrator's order shall be amended to reflect the Respondent's obligation to pay $127.44 for services by Osler Rehabilitation. A determination will also have to be made as to whether the expenses related to the follow-up in-home assessment recommended by Assessment Direct in an application dated March 2, 2010 were incurred. Some interest will be owing on the overdue payment of any benefits to which Ms. Green is found to be entitled. There is also a possibility of a special award in connection with these amounts. Finally, this decision may have an impact on the determination of entitlement to and quantum of expenses of the arbitration proceeding.

An arbitrator (other than the one who made the decision under appeal) shall determine (in the manner that he or she deems appropriate):

- whether Ms. Green is entitled to $1,074.74 for the cost of a follow-up in-home assessment recommended by Assessment Direct in an application dated March 2, 2010;
- the amount of interest owing (if the parties are unable to agree on this issue);
- whether Ms. Green is entitled to a Special Award and the amount of any such award;
- the entitlement of each party to legal expenses of the arbitration proceeding(s) and the amount of any such expenses.

Given the sums involved in this case, however, I urge the parties to attempt to resolve these (and any other) outstanding issues through negotiation.

VI. EXPENSES OF THE APPEAL

I encourage the parties to attempt to resolve the issue of the expenses related to this appeal on their own. If the parties are unable to agree about expenses of this appeal, however, an expense hearing may be arranged in accordance with Rule 79 of the *Dispute Resolution Practice Code*.

November 16, 2016

Richard Feldman
Director's Delegate

Date