LICENCE APPEAL TRIBUNAL

TRIBUNAL D'APPEL EN MATIÈRE DE PERMIS

Safety, Licensing Appeals and Standards Tribunals Ontario

Tribunaux de la sécurité, des appels en matière de permis et des normes Ontario

Ontario

2018 CanLII 13183 (ON LAT)

Date: 2018-02-09
Tribunal File Number: 17-002624/AABS
Case Name: 17-002624 v Aviva Insurance Canada

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:

M. H. E.

Applicant

and

Aviva Insurance Canada

Respondent

DECISION

ADJUDICATOR: **S. F. Mather**

APPEARANCES:

For the Applicant: Lawrence H. Calenti, Counsel

For the Respondent: Matus Averbuch, Counsel

Heard in Person: **October 23, 2017**

In-Writing: **November 14, 2017**

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Overview

[1] M. H. E. (the "applicant") was involved in a motor vehicle collision on March 23, 2016 and sought income replacement benefits, various medical benefits and costs of an assessment pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010*[1] *(*the *"Schedule")* from Aviva Insurance Company of Canada (the "respondent").

[2] The respondent denied the claims for medical benefits and the cost of the assessments on the basis that the applicant's injuries are predominantly minor injuries as defined in the *Schedule,* which can be treated within the *Minor Injury Guideline*[2] (the "*Guideline*"). The *Guideline* limits the amount of money available to an insured person for medical and rehabilitation benefits to $3,500. Payment of the benefits claimed by the applicant will result in treatment costs beyond the $3,500 limit.

[3] The applicant argues that the *Guideline* does not apply to her because she suffers from chronic pain. The applicant also argues that the lower back injury she sustained while moving a refrigerator shortly before the accident is a pre-existing medical condition that will prevent her from achieving maximal recovery if she is subject to the $3,500 limit.

[4] The respondent argues that if I determine that the *Guideline* does not apply to the applicant, I must deny the proposed Treatment and Assessment Plans ("treatment plans") because they are not reasonable and necessary.

[5] A case conference took place on July 18, 2017. The parties were unable to resolve the issues in dispute and a hearing, partly in person and partly in writing, was scheduled.

Issues

[6] The issues before me are:

1. Do the injuries sustained by M. H. E. fall within the *Guideline*?

2. If the answer to issue one is no:

    a. Is the applicant entitled to receive a medical benefit of $3,492.70 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on July 9, 2016 and denied on July 22, 2016?

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[1] O. Reg. 34/10.
[2] See section 3 O. Reg. 34/10 definition of *Minor Injury Guideline.*

b. Is the applicant entitled to receive a medical benefit of $1,886.29 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on August 27, 2016 and denied on September 12, 2016?

c. Is the applicant entitled to receive a medical benefit of $1,300 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on September 1, 2016 and denied on September 23, 2016?

a. Is the applicant entitled to receive a medical benefit of $1,467.98 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on October 24, 2016 and denied on November 12, 2016?

b. Is the applicant entitled to receive a medical benefit of $1,182.36 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on December 5, 2016 and denied on January 6, 2017?

c. Is the applicant entitled to receive a medical benefit of $2,486.00 for physiatry examination recommended by Dr. Yen Fu Chen in a treatment plan submitted on November 16, 2016 and denied on November 28, 2016?

1. Is the applicant entitled to interest for the overdue payment of benefits?

2. Is the applicant entitled to costs?

3. Is the respondent entitled to costs?

Result

[7] I find that:

1. The applicant's injuries do not fall within the *Guideline.*

2. The applicant is entitled to:

a. a medical benefit of $3,492.70 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on July 9, 2016 and denied on July 22, 2016.

b. a medical benefit of $1,886.29 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on August 27, 2016 and denied on September 12, 2016

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c. a medical benefit of $1,467.98 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on October 24, 2016 and denied on

   November 12, 2016.

d. a medical benefit of $2,486.00 for a physiatry examination recommended by Dr. Yen Fu Chen in a treatment plan submitted on November 16, 2016 and denied on November 28, 2016.

3. The applicant is not entitled to:

   a. a medical benefit of $1,300 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on September 1, 2016 and denied on September 23, 2016.

   b. a medical benefit of $1,182.36 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on December 5, 2016 and denied on January 6, 2017.

4. The applicant is entitled to interest on any overdue payment of the cost of the treatments and the physiatrist's assessment in accordance with the *Schedule.*

5. Neither party is entitled to costs.

PRELIMINARY MATTER

[8] The Order made at the case conference lists income replacement benefits ("IRBs") as an issue to be determined at the hearing. Before the hearing started the applicant withdrew her claim for IRBs. As a result of the withdrawal the respondent requested:

- an Order for costs to compensate the respondent for its preparation for the hearing of the IRB issue
- an Order that the hearing proceed as a written hearing with no in-person portion

[9] As both parties have requested costs in this matter, I will deal with the costs requests at the end of this decision.

[10] I refused to Order that the hearing proceed in-writing only and proceeded with the in-person portion of the hearing. The Order made at the Case Conference does not provide that the IRB issue would be the only issue to be heard in the in-person portion of the hearing. I was satisfied that there would be prejudice to the applicant if the in-person portion of the hearing did not proceed because

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she prepared for the hearing on the basis that she would be giving oral testimony.

APPLICABILITY OF THE MINOR INJURY GUIDELINE

[11] The *Guideline* establishes a framework for the treatment of minor injuries. The term "minor injury" is defined in section 3 of the *Schedule* as "one or more of a strain, sprain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury." The terms "strain," "sprain," "subluxation," and "whiplash associated disorder" are also defined in section 3.

[12] Section 18(1) limits recovery for medical and rehabilitation benefits for minor injuries to $3,500, minus any amounts paid in respect of an insured person under the *Guideline.*

[13] Section 18(2) of the *Schedule* makes provision for some injured persons who have a pre-existing medical condition to receive treatment in excess of the $3,500 cap. To access the increased benefits, the insured person's healthcare provider is required to determine and provide compelling evidence that the person has a pre-existing medical condition that was documented prior to the accident and which will prevent the insured person from achieving maximal recovery if benefits are limited to the *Guideline* cap.

[14] The case of *Scarlett v. Belair Insurance*[3] established that the minor injury provisions in the *Schedule* are a limit on an insurer's liability, not an exclusion from coverage, and that the onus of establishing entitlement beyond the cap rests with the claimant.

Background

[15] The 37-year-old applicant was the driver of a vehicle that was "T-boned" by another vehicle that entered the roadway from a private driveway. She did not lose consciousness in the accident but was unable to move and was taken by ambulance to Sunnybrook Health Sciences Centre, where she was admitted with full spinal precautions. She improved significantly by the second day and discharged herself from hospital on March 25, 2016, as she was concerned about getting home to her four children who were ages 4, 8, 11 and 13.

[16] The applicant attended at her family doctor on March 26, 2015, reporting weak legs, neck, back, and bilateral shoulder pain and headaches. She had decreased range of motion in her neck, back and both shoulders and bruising of her left knee. Her family doctor prescribed Robaxacet, neck and back exercises and referred her to physiotherapy.

[3] 2015 ONSC 3653 (CanLII).

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[17] She did not visit her family doctor again until June 6, 2015, at which time she reported that her shoulder, neck and back pain and right shoulder pain were worse and that she was having difficulty sleeping from the pain. Her family doctor assessed her as having acute on chronic myofascial pain in her neck and back. He again prescribed Robaxacet and neck/back exercises and referred her for physiotherapy.[4]

[18] She began physiotherapy on June 6, 2015 when she had her initial massage at North Toronto Rehab.[5] She attended regularly at North Toronto Rehab for physiotherapy, physical rehabilitation and massage therapy until early February 2017, with her last massage taking place on May 23, 2017. The applicant testified that she stopped going to therapy because the respondent refused to pay for the treatment and she could not afford to pay for it. As of August 31, 2017, she owed North Toronto Rehab $6, 596.02.[6]

[19] At the time of the accident, the applicant was receiving Employment Sickness Benefits as a result of a lumbar strain injury to her back that occurred as she was moving a refrigerator on March 8, 2016. She had not worked since September 30, 2015, when she was laid off from her job as a dispatcher for a transport company due to a shortage of work. Employment Insurance agreed to convert her regular benefits to sick benefits as a result of her back injury.[7]

[20] The applicant has not returned to work since the accident. She tried working as a grocery store cashier but was unable to tolerate being on her feet. She has not returned to doing all of the household chores she was responsible for before the accident and is unable to participate in the same recreational activities with her children. Her boyfriend and children assist with the household chores and her boyfriend now assists her with driving the children to their activities.

Impairments

[21] The applicant has satisfied me on the balance of probabilities that, as a result of the accident, she suffered more than predominantly minor injuries and is entitled to receive medical benefits in excess of the *Guideline* limit.

[22] In reaching this conclusion, I rely on the following evidence:

- The applicant's testimony that she is still suffering from considerable pain in her back, neck and shoulders and headaches over 18 months post-accident, which limits her stamina and physical activity.

[4] Tab 7, Applicant's Document Book
[5] Tab 23, Applicant's Document Book
[6] Tab 22, Applicant's Document Book
[7] Tab 18, Applicant's Document Book

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- The June 6, 2016 finding of Dr. P.N. that the applicant suffers from acute chronic myofascial pain in her neck and back.[8]

- The chronic pain diagnosis of physiatrist Dr. C who specializes in the management of pain and disability.[9]

- The findings of her family doctor, Dr. P.N, Dr. A., the insurance examiner and Dr. C. that pain causes the applicant to have a limited range of motion in her neck, back and shoulders.[10]

- The July 17, 2017 report of Dr. A's, which limits his opinion that the applicant suffered from a predominantly minor injury to "*a musculoskeletal point of view*".

- Aside from a minor lower back strain suffered shortly before the accident moving a refrigerator, the applicant has no history of suffering from neck, shoulders or back pain or numbness in her legs. The applicant's range of motion was normal in all directions following the refrigerator incident.[11]

[23] To dispute the applicant's position that she did not suffer predominantly minor injuries in the accident, the respondent relies on the opinions provided by its insurance examiner, Dr. A., following two physical examinations[12] of the applicant and a paper review. Dr. A's opinion is that the applicant sustained predominantly minor injuries that are treatable within the *Guideline.* I give little weight to the opinion of Dr. A for the following reasons:

- Dr. A's conclusion in his report dated September 8, 2016 that he found no objective evidence of any residual musculoskeletal impairment contradicts his findings on his cervical spine examination that the applicant had limited flexion, extension and rotation and that her ability to laterally bend to the left and right was only 50% of normal. It also contradicts his finding on his lumbosacral spine examination that the applicant's forward flexion, backward extension and lateral bending were well below normal.

- Dr. A's July 18, 2017 report finds the applicant's cervical spine flexion and extension to be 60% of normal, her shoulder adduction range to be limited, and her lumbosacral spine to have 60% range of motion yet he concludes that she has no objective evidence of residual musculoskeletal impairment attributable to the injuries sustained in the accident.

[8] Tab 7, Applicant's Document Book
[9] Tab 21, Applicant's Document Book
[10] Tabs 7, 19, 23 and 21, Applicant's Document Book
[11] March 10, 2016 Patient Encounter Note, Tab 16, Applicant's Document Book
[12] Tabs 19 and 23 Applicant's Document Book

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- Dr. A's July 18, 2017 report indicates that he reviewed the February 13, 2017 report of physiatrist Dr. C but does not comment on Dr. C's findings or his diagnosis of chronic pain.

- Dr. A's July 18, 2017 report reviews the applicant's activities of daily living and indicates the applicant reported pain is a limiting factor for the applicant in all of her activities and yet he does not comment on the pain in his summary and limits his opinion to a musculoskeletal point of view.

[24] The respondent questions the credibility of the applicant and in its supplementary written submissions points out inconsistencies in the applicant's story. Having heard oral testimony from the applicant that was tested by cross-examination, I find the applicant to be a credible witness. English is not the first language of the applicant and while she is able to communicate in English it became clear during her testimony that she has difficulty phrasing her answers in a way that is easily understood. The applicant acknowledged in her testimony that any inconsistencies between the medical reports and her evidence may be as a result of her misunderstanding the questions she was asked.

[25] In his August 2016 report, Dr. A. makes the allegation that the applicant was magnifying her behaviour "as *evident by tenderness to light touch over the cervical and lumbosacral spine and positive hands by the side test".* The respondent relies on this to question the credibility of the applicant. Dr. A. states that casual observation showed much better range of motion than elicited on physical examination. This observation of Dr. A, during his first meeting with the applicant, does not convince me that the applicant was magnifying her behaviour in light of the fact that both Dr. P.N. and Dr. C. found the applicant to have pain over these areas. Dr. A. does not make this allegation in his July 17, 2017 report where he also physically examined the applicant and found her cervical spine, shoulders and thoracic/lumbosacral spine to still show tenderness to light touch.

[26] The respondent questions the applicant's credibility with respect to the nature and duration of her chronic pain. The respondent argues that the applicant's testimony at the hearing, where she stated that by February, 2017 she showed a 50-60% improvement, contradicts her report to Dr. C. on February 13, 2017 that the severity of the complaints remained the same since the onset. After hearing the testimony of the applicant, I am satisfied on the balance of probabilities that applicant did not understand the question. I understand the applicant's evidence to be that the therapy gave her temporary relief from her pain, but did not eradicate it.

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[27] Decisions of both the Financial Services Commission of Ontario ('FSCO")[13] and this Tribunal[14] have recognized that chronic pain is a condition that will take an insured out of the *Guideline* if the pain is shown to be more than a sequelae of a predominantly minor injury.

[28] Based on the duration of time the applicant has experienced limitations in her activities of daily living from ongoing pain, the medically uncontroverted diagnosis of Dr. P.N. and the expert opinion of Dr. C., I am satisfied that her chronic pain is of a nature to take her out of the *Guideline.*

Did the applicant have a pre-existing medical condition entitling her to be treated outside of the *Guideline?*

[29] Having determined that the applicant's impairments sustained in the accident are not predominantly minor injuries, there is no need for me to consider if her pre-existing back injury entitles her to be treated outside of the *Guideline.* I note, however, that Dr. C. provides the opinion that because of her pre-existing condition she would not follow the normal healing time and requires treatment beyond the $3500 limit.

[30] Because her impairments are not predominantly minor injuries she is entitled to treatment in excess of the $3500 *Guideline* limit.

TREATMENT AND ASSESSMENT PLANS

[31] Section 15(1) of the *Schedule* obligates the respondent to pay for all reasonable and necessary medical expenses incurred by the applicant for specified services including medical, chiropractic, and physiotherapy services. The evidence of the applicant is that the treatments she received were reasonable and necessary because they provided short-term pain relief and increased her ability to participate in activities of daily living.

[32] The respondent objects to all of the treatment plans in issue on the basis that the treatment and assessments proposed do not meet the test of being reasonable and necessary. The respondent argues that evidence that a treatment was helpful is not sufficient to show that the treatment plan was reasonable and necessary.[15] The respondent further argues that the treatment goals as defined in the plans are not being met to a reasonable degree by the treatment and as a result the costs of achieving the goals as outlined in the treatment plans are not reasonable.[16]

[13] *Arruda v. Western Assurance Co. ,* O.F.S.C.D. No. 177; 2015 Carswell 10852
[14] *Y.X.Y. and The Personal Insurance Company*, 2017 CarswellOnt 14355; 16-000438/AABS
[15] Paragraph 20, Respondent's Supplementary Written Submissions
[16] Paragraph 25, Respondent's Submissions

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[33] Decisions[17] from FSCO have found that pain relief is a legitimate medical and rehabilitative goal and that if through reduction of pain, supportive care can improve or at least maintain a person's level of function that is a legitimate goal.[18] While I am not bound by these decisions, I find them helpful in analyzing the treatment plans in issue. Additional factors to be considered in determining the reasonableness of long-term passive therapies are:

- Credibility of the insured person and whether he or she is sincerely motivated to return to his or her pre-accident activities, including work;
- Whether the treatment team takes a consistent approach recommending a reasonable progression of treatment;
- Whether the insured person and treatment plan utilize a variety of modalities and adjust the frequency of treatments based upon his or her current needs; and
- Whether passive modalities are relied upon to the exclusion of other treatment alternatives (i.e. whether there is *inappropriate* dependence on passive modalities or the treatment in question *interferes with aspects of rehabilitation)*

[34] I find the applicant's testimony with respect to her desire to return to her pre-accident homemaking activities, activities with her four children and to work to be credible and sincere. She answered the questions in a forthright manner and I did not detect any unwillingness to participate in treatment that will allow her to achieve these goals.

Is the applicant entitled to receive a medical benefit of $3,492.70 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on July 9, 2016 and denied on July 22, 2016[19]?

[35] The applicant is entitled to this treatment plan as I am satisfied that it is reasonable and necessary. This is the first treatment plan submitted by the applicant and was denied because the applicant was placed within the *Guideline*. The plan proposes 37 treatment sessions over 10 weeks, including chiropractic services, massage therapy and physical therapy with the goal of pain reduction, increased range of motion and increase in strength—all which are issues for the applicant. The functional goals of returning to activities of daily living, returning to pre-accident or modified work activities and having 75% recovery by the end of the 10 week plan are reasonable and necessary.

[17] *General Assurance Co. of Canada v. Violi*, 2000 CarswellOnt 3453; [2000] O.DF.S.C.I.D No.171
[18] *West v. Aviva Canada Inc.* 2012 Carswell 1868; FSCO A09-002136
[19] Tab 8, Applicant's Document Book

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Is the applicant entitled to receive a medical benefit of $1,886.29 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on August 27, 2016 and denied on September 12, 2016?[20]

[36] The applicant is entitled to this benefit. This treatment plan which proposes 20 sessions of treatment over five weeks, including chiropractic, massage and physical therapy has the same goals as the first treatment plan. The plan was denied because the applicant was placed in the *Guideline.* The evaluation section indicates that the applicant has made some improvement since the accident and has been feeling better overall. The plan also indicates that the applicant was busy over the summer and did not have the chance to properly rest to recuperate from her injuries.

[37] I am satisfied that this treatment plan is reasonable and necessary because the plan indicates that some improvement had been made and in my view, based on the testimony of the applicant that the treatments provided her relief, it was reasonable and necessary that the applicant continue to receive treatment.

Is the applicant entitled to receive a medical benefit of $1,300 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on September 1, 2016 and denied on September 23, 2016?[21]

[38] The applicant is not entitled to this benefit. I am not satisfied that this treatment plan is reasonable and necessary for the reason that it was submitted to access additional treatment and goods within the *Guideline* to the $3500.00 limit. It proposes four weeks of chiropractic treatment and is dated only five days after the plan I have approved above that was denied on September 12, 2017. I am not satisfied that this plan is not covered by the plan already approved.

Is the applicant entitled to receive a medical benefit of $1,467.98 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on October 24, 2016 and denied on November 12, 2016?[22]

[39] The applicant is entitled to this treatment plan. This plan is for another 15 sessions over five weeks including chiropractic, massage and physical therapy with the same functional goals as the two plans I have already approved. The plan states that the patient reports some progress with the treatment but continues to report flare-ups of her injury sites. It states that due to the severity of the accident and injuries the progress continues to be slow.

[20] Tab 9, Applicant's Document Book
[21] Tab 10, Applicant's Document Book
[22] Tab 11, Applicant's Document Book

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[40] The applicant testified that she received relief from the treatments but the relief did not last long. I approve this plan because it recognizes that some progress was made and reduces the frequency of treatment from four sessions per week to three sessions per week.

Is the applicant entitled to receive a medical benefit of $1,182.36 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on December 5, 2016 and denied on January 6, 2017?[23]

[41] The applicant is not entitled to this benefit. This treatment plan submitted almost six months after the applicant first received treatment proposes another 11 sessions over five weeks of chiropractic, physical therapy and massage therapy. The goals are the same as the earlier treatment plans.

[42] I am not satisfied that this plan is reasonable and necessary for the reason that it states that the patient had only minimal changes after a further two months of therapy. While the plan reduces the frequency of sessions, the plan does not propose any different treatments or measurable goals. All of the treatment plans up to and including this one propose chiropractic treatment as the main form of therapy. No apparent consideration is given to whether other modalities of treatment may be more effective to alleviate the applicant's pain and increase her range of movement.

Is the applicant entitled to receive a medical benefit of $2,486.00 for a physiatry examination recommended by Dr. Yen Fu Chen in a treatment plan submitted on November 16, 2016 and denied on November 28, 2016?

[43] The applicant is entitled to receive the cost of Dr. C.'s examination as I am satisfied that is was reasonable and necessary given the applicant's evidence of ongoing range of motion, numbness and pain issues following the accident.

Interest

[44] Having found that the applicant is entitled to some of the benefits claimed, I find that she is entitled to interest on any overdue payments of benefits in accordance with the *Schedule.*[24]

Costs

[45] Both the applicant and respondent request costs in their written submissions for the hearing.

[23] Tab 12, Applicant's Document Book
[24] Section 51(2) O. Reg. 34/10.

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[46] Rule 19.1 of the Tribunal's *Rules* allows a party to make a request to the Tribunal for costs where it believes another party in a proceeding has acted unreasonably, frivolously, vexatiously, or in bad faith.

[47] The applicant has not pointed to any behaviour of the respondent which she relies on to show that it has acted unreasonable, frivolously, vexatiously or in bad faith in these proceedings and for that reason her claim for costs is dismissed.

[48] The respondent argues that it is entitled to costs for the reason that the applicant acted unreasonably in not withdrawing her claim for income replacement benefits until the day of the hearing. The respondent submits that the sole reason for the in-person portion of the hearing was to address the income replacement benefit and that it incurred significant legal costs to prepare for the hearing of the income replacement benefit issue.

[49] I have no evidence that the applicant acted unreasonably in withdrawing her claim for income replacement benefits on the day of the hearing and for that reason I dismiss the respondent's claim for costs. I accept the applicant's evidence[25] that the respondent knew as early as September 19, 2017 that the applicant was considering withdrawing her claim for income replacement benefits.

[50] By September 22, 2017 it should have been clear to the respondent that the IRB issue was not being pursued because the applicant's written submissions do not list it as an issue and the applicant's document book does not include any evidence on the income replacement issue. Based on these facts I do not find any behaviour to warrant a cost order.

Order

[51] For the reasons provided above, I **Order** the following**:**

1. The applicant's injuries are not predominantly minor injuries and do not fall within the *Guideline.*

2. The applicant is entitled to:

    a. a medical benefit of $3,492.70 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on July 9, 2016 and denied on July 22, 2016.

    b. a medical benefit of $1,886.29 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on August 27, 2016 and denied on September 12, 2016.

[25] Tab 1, Response to Supplementary Written Submissions on the Respondent

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c. a medical benefit of $1,467.98 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on October 24, 2016 and denied on November 12, 2016.

d. a medical benefit of $2,486.00 for a physiatry examination recommended by Dr. Yen Fu Chen in a treatment plan submitted on November 16, 2016 and denied on November 28, 2016.

3. The applicant is not entitled to:

a. a medical benefit of $1,300 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on September 1, 2016 and denied on September 23, 2016.

b. a medical benefit of $1,182.36 for chiropractic services recommended by North Toronto Rehabilitation in a treatment plan submitted on December 5, 2016 and denied on January 6, 2017.

4. The respondent shall pay to the applicant interest on any overdue payments of the costs of the medical benefits ordered in accordance with the *Schedule.*

5. Neither party is entitled to costs.

Released: February 9, 2018

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Susan F. Mather, Vice-Chair

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