Financial Services
Commission
of Ontario

Commission des
services financiers
de l'Ontario

FSCO A13-004272

BETWEEN:

YA LIN DAVE LI

Applicant

and

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY

Insurer

REASONS FOR DECISION

Before: Arbitrator Janette Mills

Heard: In person at ADR Chambers on November 18, 19 and 20, 2015

Appearances: Mr. Adam Ezer participated for Mr. Ya Lin Dave Li
Mr. Jonathan Schrieder participated for State Farm Mutual Automobile Insurance Company

Issues:

The Applicant, Mr. Ya Lin Dave Li, was injured in a motor vehicle accident on January 14, 2010 and sought accident benefits from State Farm Mutual Automobile Insurance Company ("State Farm"), payable under the *Schedule*.[1] The parties were unable to resolve their disputes through mediation, and Mr. Li, through his representative, applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c. I.8, as amended. Pre-Hearing discussions were held on June 24, 2014.

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

The issues in this Hearing are:

1. Is the Applicant entitled to receive medical benefits as follows:
    a) $972.51 for driving assistive devices provided by Pacific Assessment Centre, treatment plan, dated August 5, 2010?
    b) $881.71 for relaxation CDs provided by Pacific Assessment Centre, treatment plan, dated August 16, 2010?
    c) $990.00 for custom orthotics and completion of an OCF-18 provided by Pacific Assessment Centre, treatment plan, dated May 8, 2010?
2. Is the Applicant entitled to payment for the cost of examinations as follows:
    a) $1,743.72 for a follow-up attendant care assessment #3 provided by Fairview Assessment Centre, dated May 11, 2010?
    b) $1,743.72 for a follow-up attendant care assessment #4 provided by Fairview Assessment Centre, dated July 13, 2010?
    c) $2,413.72 for a family and social assessment and completion of an OCF-22 provided by Pacific Assessment Centre, dated June 23, 2010?
    d) $2,313.72 for a driving assessment and completion of an OCF-22 provided by Pacific Assessment Centre, dated June 29, 2010?
3. Is the Applicant entitled to a special award?
4. Is the Applicant entitled to interest on any amounts owing?
5. Is State Farm liable to pay the Applicant's expenses in respect of the Arbitration?
6. Is the Applicant liable to pay State Farm's expenses in respect of the Arbitration?

Result:

1. The Applicant is entitled to receive medical benefits as follows:
    a) $972.51 for driving assistive devices provided by Pacific Assessment Centre, treatment plan, dated August 5, 2010;
    b) $881.71 for relaxation CDs provided by Pacific Assessment Centre, treatment plan, dated August 16, 2010;

c) $990.00 for custom orthotics and completion of an OCF-18 provided by Pacific Assessment Centre, treatment plan, dated May 8, 2010.

2. The Applicant is entitled to payment for the cost of examinations as follows:

   a) $1,743.72 for a follow-up attendant care assessment #3 provided by Fairview Assessment Centre, dated May 11, 2010;

   b) $1,743.72 for a follow-up attendant care assessment #4 provided by Fairview Assessment Centre, dated July 13, 2010;

   c) $2,413.72 for a family and social assessment and completion of an OCF-22 provided by Pacific Assessment Centre, dated June 23, 2010;

   d) $2,313.72 for a driving assessment and completion of an OCF-22 provided by Pacific Assessment Centre, dated June 29, 2010.

3. State Farm is liable to pay a special award in the amount of $25,165.59 because it unreasonably withheld payments to the Applicant.

4. The Applicant is entitled to interest for the overdue payments of benefits at the prescribed rate.

5. State Farm is liable to pay the Applicant's expenses in respect of the Arbitration.

EVIDENCE AND ANALYSIS:

Background

The Applicant was injured in a motor vehicle accident on January 14, 2010. There was no dispute between the parties regarding the Applicant's injuries and the chronology of the accident benefit claim. At the commencement of the Hearing, the parties advised that the only issues to be determined are the Applicant's entitlement to the listed medical benefits, cost of examinations, interest on any amounts owing and a special award.

Should the Applicant succeed in his claim for Medical Benefits and Cost of Examinations?

The Applicant applied for accident benefits on January 18, 2010.[2] On January 22, 2011, State Farm provided an Explanation of Benefits ("OCF-9") to the Applicant indicating that it had received his treatment and assessment plans, dated January 19, 2010 to August 21, 2010, from Fairview Assessment Centre. It went on to state that State Farm was currently in a dispute with Fairview Assessment Centre, and for that reason was unable to consider his treatment and assessment plans.[3]

On January 24, 2011, State Farm provided an OCF-9 to the Applicant indicating that it had received treatment and assessment plans, dated May 8, 2010 to August 17, 2010, from Pacific Assessment Centre. It went on to state that it was currently in a dispute with Pacific Assessment Centre, and for that reason was unable to consider his treatment and assessment plans.[4]

In total, 38 Treatment Plans ("OCF-18"), 26 Applications for Approval of an Assessment or Examination ("OCF-22"), 1 attendant care assessment and 4 follow-up assessments, 1 in-home assessment and 3 follow-up assessments, plus 5 other assessments took place between January and August 2010. A myriad of further examinations/assessments are said to have taken place up until July 2011. The majority of services provided were by Pacific Assessment Centre and Fairview Assessment Centre, with a few services being provided by Toronto Healthcare Inc.

The sole issue before me is whether or not State Farm was entitled to withhold medical benefits and the cost of examinations from the Applicant.

The Position of the Applicant

The Applicant submits that whilst State Farm is entitled to refuse to pay for the benefits requested, it must do so in the correct way, according to the statutory scheme, and that it failed to do so in this circumstance. The *Schedule* requires the Insurer to consider the benefit applied for. It requires the Insurer to give notice that the benefit is being approved for payment or not and if not, its

[2] Exhibit 1, Tab C1 at p. 66.
[3] *Ibid.*, Tab G7 at p. 247.
[4] *Ibid.*, Tab C8 at p. 251.

reasons for refusing payment. It is at that point that State Farm can refuse payment, on the basis that the goods and services are neither reasonable and or necessary, or for some other reason. Furthermore, the reasonableness of the Applicant's claims can only be determined once the claims have been considered. In essence, State Farm, by not considering the treatment and assessment plans, placed the burden of its dispute with the service providers on the shoulders of the Applicant.

The Position of State Farm

State Farm does not dispute that it failed to meet the notice provisions of the *Schedule*. Rather, State Farm submits that the Applicant's accident benefit claims were not reasonable, and that pursuant to the *Schedule,* the Insurer is not required to pay for benefits or assessments which are not reasonable and necessary. The legislation must be read contextually and it would be an absurdity if State Farm is required to pay for goods and services that are neither reasonable nor necessary. Furthermore, some of the medical benefits were incurred prior to the treatment plans being submitted to the Insurer and for that reason are not payable.

Analysis

The Legislative Scheme

The provisions of the *Schedule* relevant to the claims in this matter are set out as follows:

Medical and Rehabilitation Benefits

38. (1) Subject to subsection (2.1), this section applies to,

(a) any claim for medical or rehabilitation benefits other than,

(i) a claim payable under section 37.1, and

(ii) a claim for ancillary goods and services referred to in section 37.2; and

(b) applications for assessments or examinations that are submitted with a treatment plan under subsection (2).

(1.1) An insurer is not liable to pay any expense in respect of medical benefits or rehabilitation benefits that was incurred before the insured person submits an application for the benefit that satisfies the requirements of subsection (2) unless the expense is for an ambulance or other goods or services provided on an emergency basis not more than five business days after the accident to which the application relates.

(2) An application under this section must be signed by the insured person, unless the insurer waives that requirement, and must include, unless section 38.1 applies,

> (a) a treatment plan that complies with subsection (3), prepared by a member of a health profession or by a social worker; and
>
> (b) a statement by a health practitioner approving the treatment plan referred to in clause (a) and stating that he or she is of the opinion,
>
> > (i) that the expenses contemplated by the treatment plan are reasonable and necessary for the insured person's treatment or rehabilitation, and
> >
> > (ii) that the impairment sustained by the insured person does not come within a *Pre-approved Framework Guideline*.

…

(5) If a conflict of interest is disclosed under subsection (3) or (4), the insurer may, within 10 business days after receiving the application, give the insured person notice that the application is refused and that the insured person may submit a new application.

…

(7) On receiving the application, the insurer shall promptly determine whether the insurer is required to pay for the goods and services contemplated by the treatment plan.

(8) If no notice is given under subsection (5), the insurer shall give the insured person one of the following notices:

> 1. A notice,
>
> > i. that discloses any conflict of interest the insurer has relating to the treatment plan,
> >
> > ii. that describes the goods and services, if any, contemplated by the treatment plan that the insurer agrees to pay for, and
> >
> > iii. that advises the insured person, if the insurer has not agreed to pay for all goods and services contemplated by the treatment plan, that the insurer

requires the insured person to be examined under section 42 relating to the goods and services the insurer has not agreed to pay for.

2. A notice advising the insured person that the insurer,

i. believes that the insured person may have an impairment to which a *Pre-approved Framework Guideline* applies, and

ii. requires the insured person to be examined under section 42 to assist the insurer in determining if the insured person has an impairment to which a *Pre-approved Framework Guideline* applies.

(8.1) A notice under subsection (8) must be given,

(a) within 10 business days after the insurer receives the application, in the case of a notice described in paragraph 1 of subsection (8); or

(b) within five business days after the insurer receives the application, in the case of a notice described in paragraph 2 of subsection (8).

(8.2) If the insurer fails to give a notice under subsection (8) in accordance with subsection (8.1), the following rules apply:

1. In the case of a notice under paragraph 2 of subsection (8),

i. the insurer shall not take the position that the insured person has an impairment to which a *Pre-approved Framework Guideline* applies, and

ii. the insurer shall give a notice described in paragraph 1 of subsection (8) in accordance with subsection (8.1).

2. In the case of a notice under paragraph 1 of subsection (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 described in paragraph 1 of subsection (8).

Application for Approval of an Assessment or Examination

38.2 (1) This section applies to an application prepared by a member of a health profession or social worker for approval of an assessment or examination of an insured person if the application is not submitted as part of a treatment plan under section 38.

(2) The application shall include a statement by the member of a health profession or social worker who is to conduct the assessment or examination,

(a) disclosing any conflict of interest that he or she has relating to the assessment or examination to which the application relates;

(b) indicating that he or she has made reasonable inquiries to determine whether any person who referred the insured person to him or her has a conflict of interest relating to the assessment or examination and, if there is a conflict of interest, disclosing the conflict of interest that the person has; and

(c) stating that the assessment or examination is reasonably required in relation to a benefit.

(3) A lawyer or other representative who acts for the insured person in respect of the application or with respect to any civil proceeding arising from the accident shall, at the time the application is submitted, give the insurer and the insured person written notice disclosing any conflict of interest that the lawyer or other representative has relating to the application.

(4) If a conflict of interest is disclosed under subsection (2) or (3), the insurer may refuse the application and, within two business days after receiving the application, give the insured person notice that the application is refused and that the insured person may submit a new application.

(5) Despite subsection (4), the insurer shall not refuse the application because of a conflict of interest if there is no other person within 50 kilometres of the insured person's residence who is able to conduct the assessment or examination.

(6) If the insurer has not refused the application under subsection (4), the insurer shall give the insured person and the person who prepared the application a notice,

(a) within two business days after receiving the application if the application is received before March 1, 2006 and the amount to be charged is $180 or less;

(b) within five business days after receiving the application if the application is received before March 1, 2006 and the amount to be charged exceeds $180; or

(c) within three business days after receiving the application, if the application is received on or after March 1, 2006.

(7) The notice under subsection (6) must,

(a) state which assessments or examinations in the application the insurer agrees to pay for;

(b) advise the insured person that the insurer requires the insured person to be examined under section 42, if the insurer has not agreed to pay for all assessments or examinations to which the application relates; and

(c) disclose any conflict of interest that the insurer has relating to any assessment or examination to which the application relates.

(8) A notice required under subsection (6) may be given verbally if, as soon as practicable afterwards, written confirmation of the notice is given to every person who received verbal notice.

(9) If the insurer does not refuse the application under subsection (4) but fails to give the notice as required under subsection (6), the insurer shall pay for all assessments and examinations to which the application relates.

…

(13.5) An insurer shall pay for all assessments and examinations that it has agreed to pay for or that it is required under this section to pay for within 30 days after receiving an invoice for the cost of the assessment or examination.

Attendant Care Benefits

39. (1) An application for attendant care benefits for an insured person must be in the form of an assessment of attendant care needs for the insured person that is prepared and submitted to the insurer by a member of a health profession who is authorized by law to treat the person's impairment.

(2) Within 10 business days after receiving the assessment of attendant care needs, the insurer shall give the insured person a notice that,

(a) advises the insured person which, if any, expenses described in the assessment of attendant care needs the insurer agrees to pay; and

(b) advises the insured person that the insurer requires the insured person to be examined under section 42, if the insurer has not agreed to pay all expenses described in the assessment of attendant care needs.

> (3) An insurer may, but is not required to, pay an expense incurred before an assessment of attendant needs that complies with subsection (1) is submitted to the insurer.
> (4) The insurer shall begin payment of attendant care benefits within 10 business days after receiving the assessment of attendant care needs and, pending receipt by the insurer of the report of any examination under section 42 required by the insurer, shall calculate the amount of the benefits based on the assessment of attendant care needs.
> (5) If an insurer wants to determine if an insured person is still entitled to attendant care benefits, wants to determine if the benefits are being paid in the appropriate amount or wants to determine both, the insurer shall give the person a notice requesting that a new assessment of attendant care needs for the insured person that complies with subsection (1) be submitted to the insurer within 10 business days after the insured person receives the notice.
> (6) Subject to subsection (10), a notice under subsection (5) may also advise the insured person that the insurer requires the insured person to be examined under section 42.
> (7) Subject to subsection (10), new assessments of attendant care needs may be submitted to an insurer at any time there are changes that would affect the amount of the benefits.
> (8) If a new assessment of attendant care needs indicates that it is appropriate to increase the amount of the attendant care benefits and the insurer has not already advised the insured person that the insurer requires the insured person to be examined under section 42, the insurer may give a notice to the insured person advising that the insurer requires the insured person to be examined under section 42.
> (9) If a new assessment of attendant care needs is required under subsection (5) or the insurer requires an examination under section 42, the insurer shall, subject to section 18, continue to pay the insured person attendant care benefits at the same rate until the insurer receives the assessment of attendant care needs or the report of the examination, as applicable.

In my view, s. 38, s. 38.2 and s. 39 require the Insurer to consider the treatment plan and/or assessment and examination before rejecting it. For example, in *Halim and Security National*, Director's Delegate Blackman reviewed s. 24 and its interaction with s. 38:

> If an insurer could withhold referring a matter to a DAC because it was not satisfied that the assessment was reasonably required, then no application would be referred to a DAC, notwithstanding that a main purpose of the DAC assessment is to independently and expertly opine on the question of reasonableness.[5]

Although referral to a Designated Assessment Centre is not a relevant consideration in this case, the principles remain the same; that is to say that one can only arrive at a determination of reasonable and necessary after an examination and/or assessment is conducted from the information provided. State Farm never actually denied the medical benefits and examinations on the basis that they were not reasonable and necessary. It simply issued an OCF-9 a year later, with a blanket statement that it was "unable to consider his treatment and assessment plans."

At no time prior to January 22, 2011 did State Farm correspond with the Applicant regarding the impugned medical benefits and examinations. There were no concerns raised by State Farm with respect to the Applicant's application for accident benefits, and nothing to suggest that in State Farm's view the application did not meet the statutory requirements of the *Schedule*.

Therefore, in my view, State Farm was obligated to comply with the notice provisions of the *Schedule*: s. 38(8), s. 38.2(6) and s. 39(2). Since it failed to do so, s. 38(8.2), s. 38.2(9) and s. 39(4) apply. I am aided in this view by the recent decision of Arbitrator Smith in *Lin and State Farm*,[6] a case which is on all fours with the one before me, wherein he found, *inter alia*, that the Insurer was obligated to comply with the notice provisions of the *Schedule*.

What must State Farm pay for?

The Assistive Devices

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[5] *Halim and Security National Insurance Co./Monnex Insurance Mgmt. Inc.*, FSCO Appeal P07-00035 (August 8, 2008) at p. 5.

[6] *Lin and State Farm Mutual Automobile Insurance Company*, FSCO A12-007465 (June 23, 2015).

According to the OCF-18s and the invoices ("OCF-21s"), the assistive devices supplied to the Applicant by Pacific Assessment Centre were:

- driving assistive devices (a blind spot mirror, clip-on wide angle panoramic mirror, custom air backrest, easy reach seat belt, ergonomic side to side seating pillow, easy grip steering wheel cover);
- a set of relaxation CDs for driving; and
- custom-made orthotics.

State Farm submits that the assistive devices were incurred before the treatment plans were submitted, and for that reason are not payable.

According to the facsimile transmission, the OCF-18 regarding the orthotics was submitted on May 14, 2010. The Applicant testified that he signed the "confirmation of orthotic dispensing form" on June 19, 2010.

I find the Applicant to be a credible witness, and I am satisfied from his testimony that he received the orthotics on June 19, 2010. I recognize that the OCF-21 was submitted on June 2, 2010 and indicates that "service was provided" on May 8, 2010. However, the Applicant testified the orthotics were custom-made, and I accept that time was required for preparation and delivery between the order and the delivery to the Applicant on June 19, 2010.

Although State Farm submits that the best evidence is the date on the OCF-21s regarding when service was provided, in my view, a common sense reading of all the relevant OCF-21s suggests that this refers to the date the treatment plan was devised. One need only to reference the OCF-18s, which state no service had been provided as of the dates the OCF-18s were submitted.[7]

This reasoning applies equally to the driving CDs and driving assistive devices which the

[7] Exhibit 3, Tab 4A at p. 862; Exhibit 4, Tab L at p. 934; Tab O at p. 952.

Applicant testified that he received on November 17, 2010 and November 29, 2010, respectively.[8] Therefore, I am persuaded that the orthotics, driving CDs and driving assistive devices were not "incurred" before the application was submitted, and do not come within s. 38(1.1).

If the Insurer does not give notice to the Applicant in accordance with s. 38(8.1), then s. 38(8.2) applies. Pursuant to s. 38(8.2), the Insurer must pay for goods and services *provided* under the treatment plan that relate to the period starting on the eleventh business day after the Insurer received the application. Therefore, the determination of whether or not State Farm must pay rests on whether or not the goods and services which are the subject of the treatment plan were *provided* to him during the period described in s. 38(8.2).

In my view, the weight of the evidence establishes on a balance of probabilities that the custom-made orthotics, driving CDs and driving assistive devices were provided to the Applicant after the eleventh day deadline provided for in s. 38(8.2) and before receipt of State Farm's OCF-9 denial, dated January 24, 2011.[9] Therefore, the goods and services were provided pursuant to the *Schedule* and are payable.

The follow-up attendant care assessment #3 and follow-up attendant care assessment #4 both performed by Dr. S. Tamir from Fairview Assessment Centre, dated May 13, 2010 and July 15, 2010, respectively.

I accept the evidence of Dr. Tamir that the follow-up attendant care assessments took place. I am aided in this view by the testimony of the Applicant who, although he did not recall the name of the service provider, recalled being interviewed at his home on a number of occasions and asked questions regarding his functional abilities in the home.

Although the assessment reports indicated they had been prepared under the supervision of a Dr. Grossi, Dr. Tamir's testimony indicated that he was asked by the clinic to include the name on the report cover page even though the report was authored by him. I find his explanation reasonable.

[8] Exhibit 4, Tab HH at pages 1095, 1098 and 1099.
[9] *Supra*, note 4.

In addition, I also note that State Farm did not seriously contest the issue of whether or not the assessments were done, but rather relied on whether they were reasonable and necessary given their frequency and the nature of the Applicant's injuries. As stated, above, in my view, reasonableness and necessity can only be determined once the claim is considered.

Section 39(4) states that the Insurer shall begin payment of attendant care benefits within 10 business days of receiving an assessment of attendant care needs. No prior approval is required in respect of an assessment or examination for the purposes of preparing a Form 1.[10] Having found that both follow-up assessments were conducted and that State Farm did not comply with the notice provisions of s. 39(2) or with s. 39(4), both are payable under the *Schedule*.

The family and social assessment and completion of an OCF-22 performed by Avi Davis from Pacific Assessment Centre, dated June 23, 2010

I accept the testimony of Avi Davis that he assessed the Applicant and prepared the report. I am aided in this view by the notes of Avi Davis with respect to his interview with the Applicant, and the Applicant's testimony wherein he identified the questionnaires and his handwriting.[11] Section 38.2(6)(c) states that the Insurer must give notice within three business days of receiving the assessment. Section 38.2(9) states that if the Insurer fails to give notice then the Insurer shall pay for all assessments and examinations to which the application relates. Avi Davis' assessment was conducted on July 19, 2010, after the three day deadline stipulated in s. 38.2(6)(c) and before receipt of State Farm's OCF-9 denial on January 24, 2011. Therefore, the assessment is payable.

The driving assessment and completion of an OCF-22 performed by Dr. L. Steiner from Pacific Assessment Centre, dated June 29, 2010

Dr. Steiner testified that he did not prepare the driving assessment and that it was done by a psychometrist trained by him and working under his supervision. The psychometrist was not available to testify. She had moved from Ontario, and he was unable to contact her prior to the

[10] *Schedule*, s. 24(1.2)5.
[11] Exhibit 12.

Hearing. His attempts to contact her were by an email which was unanswered, and a phone call similarly unanswered.

Dr. Steiner testified that it is standard practise in any event for a health care professional to use an agent under their supervision to conduct testing. Dr. Steiner testified that he had never met the Applicant, but he reviewed the report with the psychometrist and signed the report. He had no notes of having done so.

State Farm submits that Dr. Steiner's evidence is hearsay and not admissible. The Applicant submits that Dr. Steiner's evidence is the best evidence available in the circumstances and should be relied upon. I accept that Dr. Steiner's evidence is the best evidence available. Further, hearsay evidence is acceptable at Arbitration Hearings.[12] The evidence of Dr. Steiner is relevant and admissible—the weight to be attributed to that evidence is for me to determine.

The Applicant testified that he attended a driving assessment that was conducted by a woman. He did not recall her name. He recalled a man being present, and thought that he was assisted by an interpreter. He acknowledged that his signature was on the driving assessment. Given that I found the Applicant to be credible, I accept his evidence that he attended for the driving assessment and that the report was subsequently generated by the psychometrist. Although I have some misgivings regarding the lack of any notes of Dr. Steiner, on a balance of probabilities, the weight of the evidence establishes that the report was generated under his supervision and signed by him.

State Farm submitted that there were problems with the driving assessment as follows: it was not thorough; it was unclear whether it was conducted on-road or off-road; and that there were problems with the accuracy of the report. Again, in my view, whilst these issues may be relevant in regard to a consideration of whether the service was reasonable and necessary, they are not relevant issues in a determination of whether s. 38 has been complied with.

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[12] *Salvaggio and Simcoe & Erie General Insurance Company*, Appeal Order P97-00062 (January 21, 1999).

Based on the evidence before me, I accept that the driving assessment was conducted on July 29, 2010, after the three day deadline stipulated in s. 38.2(6)(c) of the *Schedule* and before receipt of State Farm's OCF-9 denial on January 24, 2011. Therefore, the assessment is payable.

I also note that State Farm submitted that there were discrepancies in the applications. For example, sometimes the Applicant's signature predated the various health professionals' signatures, including those of Dr. Steiner and Avi Davis. The evidence before me, which I accept, is that the Applicant never signed a blank form. I am in agreement with the Applicant that the *Schedule* does not dictate the order in which the parties are to sign. Also, in regard to the use of electronic signatures, Dr. Steiner, Dr. Tamir and Avi Davis testified that they reviewed the applications and gave permission for their signatures to be used electronically, in regard to the medical benefits and assessments at issue before me.

Conclusion

For the foregoing reasons, I find that State Farm is liable to pay for the medical benefits and cost of examinations outlined above.

Interest

In regard to the payment of interest the *Schedule* provides as follows:

46. (1) An amount payable in respect of a benefit is overdue if the insurer fails to pay the benefit within the time required under this Part.
(2) If payment of a benefit under this Regulation is overdue, the insurer shall pay interest on the overdue amount for each day the amount is overdue from the date the amount became overdue at the rate of 2 per cent per month compounded monthly.

Having found that the benefits were payable in accordance with s. 38, s. 38.2 and s. 39 of the *Schedule*, the Applicant is entitled to interest at the prescribed rate.

Is the Applicant entitled to a Special Award?

Section 282(10) of the *Insurance Act* requires an Arbitrator to make a special award upon finding that an Insurer unreasonably withheld or delayed payments of benefits found to be owing. The award is a lump sum, with a fixed maximum limit, in addition to the benefits and interest owed to the Insured.

In *Plowright and Wellington*, Arbitrator Palmer described unreasonable behaviour in the withholding of payments as behaviour which was excessive, imprudent, stubborn, inflexible, unyielding or immoderate.[13]

In my view, State Farm acted unreasonably by withholding payment to the Applicant. This is particularly so given the recent decision of Arbitrator Smith in *Lin and State Farm*,[14] a case, as stated above, on all fours with the one before me.

The *Lin and State Farm* decision was issued five months before this Arbitration Hearing. It involved the same issues and arguments and the same Insurer. Notwithstanding, State Farm chose to re-litigate the same issue and made some of the same arguments in their defence. In my view, by doing so, their actions can fairly be described as stubborn, inflexible and unyielding and contrary to the purpose of the *Schedule*, which is "designed to ensure the timely submission and resolution of accident benefits".[15]

In sum, I find that State Farm acted unreasonably in withholding payment to the Applicant for the medical benefits and cost of examinations, as outlined above, once the OCF-18s, OCF-22s and follow-up assessments for attendant care were submitted and the provisions of the *Schedule* became operative.

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[13] *Plowright and Wellington Insurance Company*, FSCO A-003985, October 29, 1993 at p. 17.
[14] *Supra*, note 5.
[15] *Sagan v. Dominion of Canada General Insurance Company*, 2014 ONCA 720 at para. 8.

For the above reasons, the maximum amount of special award payable is appropriate in this case. The award is calculated on the basis of 50 per cent of the amount of the principal (the amount the Applicant was entitled to at the time of the award) and interest combined. The dollar amounts were provided to me, in submissions, by the Applicant and the amounts were not disputed by State Farm. The principal amount is $11,059.10. The interest on that amount is calculated at 2 per cent per month over the number of months outstanding, for a total of $39,272.09. Therefore, the amount of the special award is $25,165.59.

EXPENSES:

The Applicant is entitled to reasonable expenses of the Arbitration. If the parties are unable to agree on the quantum of the expenses of this matter, the parties may request an appointment with me for determination of same in accordance with Rules 75 to 79 of the *Dispute Resolution Practice Code*.

____
Janette Mills
Arbitrator

January 29, 2016
Date

Financial Services
Commission
of Ontario

Commission des
services financiers
de l'Ontario

FSCO A13-004272

BETWEEN:

YA LIN DAVE LI

Applicant

and

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY

Insurer

ARBITRATION ORDER

Under section 282 of the *Insurance Act*, R.S.O. 1990, c. I.8, as amended, it is ordered that:

1. The Applicant is entitled to receive medical benefits as follows:

   a) $972.51 for driving assistive devices provided by Pacific Assessment Centre, treatment plan, dated August 5, 2010;

   b) $881.71 for relaxation CDs provided by Pacific Assessment Centre, treatment plan, dated August 16, 2010;

   c) $990.00 for custom orthotics and completion of an OCF-18 provided by Pacific Assessment Centre, treatment plan, dated May 8, 2010.

2. The Applicant is entitled to payment for the cost of examinations as follows:

   a) $1,743.72 for a follow-up attendant care assessment #3 provided by Fairview Assessment Centre, dated May 11, 2010;

   b) $1,743.72 for a follow-up attendant care assessment #4 provided by Fairview Assessment Centre, dated July 13, 2010;

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d) $2,313.72 for a driving assessment and completion of an OCF-22 provided by Pacific Assessment Centre, dated June 29, 2010.

3. State Farm is liable to pay a special award in the amount of $25,165.59 because it unreasonably withheld payments to the Applicant.

4. The Applicant is entitled to interest for the overdue payments of benefits at the prescribed rate.

5. State Farm is liable to pay the Applicant's expenses in respect of the Arbitration.

___________________________	January 29, 2016
Janette Mills Arbitrator	Date