Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

FSCO A14-010161

BETWEEN:

LARRY WARD

Applicant

and

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY

Insurer

DECISION ON A PRELIMINARY ISSUE

Before: Arbitrator Chuck Matheson

Heard: By written submissions and oral submissions on September 17, 2015 and October 14, 2015

Appearances: Mr. D. Donnelly, lawyer, for Mr. Larry Ward
Ms. P. Grubb, paralegal, for Mr. Larry Ward
Ms. K. Tranquilli, lawyer, for State Farm Mutual Automobile Insurance Company

Issues:

The Applicant, Mr. Larry Ward, was injured in a motor vehicle accident on October 18, 2007 and sought accident benefits from State Farm Mutual Automobile Insurance Company ("State Farm"), payable under the *SABS*.[1] State Farm terminated Income Replacement Benefits on October 10, 2014. The parties were unable to resolve their disputes through mediation, and the Applicant, 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.

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

The issues in this Preliminary Issue Hearing are:

1. Is the Applicant precluded from proceeding to Arbitration for the claimed Income Replacement Benefits (IRBs)?
2. Is the Applicant precluded from proceeding to Arbitration for the claimed transportation expenses?
3. Is the Applicant precluded from proceeding to Arbitration for the claimed prescription expenses?
4. Is the Applicant precluded from proceeding to Arbitration for the claimed case management services?
5. Is either party entitled to its expenses of this Preliminary Issue Hearing?

Result:

1. IRBs claimed may proceed to Arbitration.
2. Transportation expenses claimed may proceed to Arbitration.
3. Prescription expenses claimed may proceed to Arbitration.
4. Case management services claimed may proceed to Arbitration.
5. If the parties are unable to agree on the entitlement to, or 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*.

EVIDENCE AND ANALYSIS:

Statutes and Regulations considered

Insurance Act, R.S.O. 1990, c. I.8, Sections 280 and 281.
Statutory Accident Benefits Schedule, Effective September 1, 2010, O. Reg. 34/10, Sections 14, 15, 16, 17, 37, 38, 44 and 55.

Case Law Authorities considered

Smith and Co-Operators General Insurance Co., [2002] 2 S.C.R. 129
Augustin and Unifund Assurance Company (FSCO A12-000452, November 13, 2013)
Rizzo and Rizzo Shoes Ltd. (Re), 1998 CanLII 837 (SCC)

Background

Prior to the accident, the Applicant was living with his wife and children on a farm property and was working in full time employment.

The Applicant has been receiving IRBs since the date of loss until October 2014. The Applicant was deemed catastrophic in December 2014 by the Insurer.

The Preliminary Issue Hearing

1. Is the Applicant precluded from proceeding to Arbitration for the claimed IRBs?

In review of the written submissions, the Insurer requested that the Applicant attend four (4) section 44 Insurers Examinations for the purposes of evaluating whether the Applicant should continue to receive IRBs. As the Applicant did not attend the examinations as requested, the Insurer is seeking to preclude the Applicant from proceeding to Arbitration on this matter by virtue of section 55(2) of the *SABS*, which reads as follows:

55. An insured person shall not commence a mediation proceeding under section 280 of the Act if any of the following circumstances exist:

1. The insured person has not notified the insurer of the circumstances giving rise to a claim for a benefit or has not submitted an application for the benefit within the times prescribed by this Regulation.
2. The insurer has provided the insured person with notice in accordance with this Regulation that it requires an examination under section 44, but the insured person has not complied with that section.

It is uncontested evidence that the Applicant has already attended and provided the Insurer with no less than nine (9) IRB medical examinations, including those for his catastrophic designation that was recognized by the Insurer some six (6) weeks after the IRB was terminated.

The Applicant argues, in part, that the Insurer did not follow and satisfy sections 37(1)(b) and/or 44(5)(a) of the *SABS*. Section 37(1) reads, in part, as follows:

37. (1) If an insurer wishes to determine if an insured person is still entitled to a specified benefit, the insurer may, but not more often than is reasonably necessary,

(a) request that the insured person submit, within 15 business days, a new disability certificate completed as of a date on or after the date of the request;

(b) notify the insured person that the insurer requires an examination under section 44; or,

Section 44(5) reads, in part, as follows:

44. (5) If the insurer requires an examination under this section, the insurer shall arrange for the examination at its expense and shall give the insured person a notice setting out,

(a) the medical and any other reasons for the examination;

The Applicant concedes that section 37(1) does trigger a request for an examination under section 44, but this should only be exercised not more often than is "reasonably necessary".

The Applicant argues, in part, that the Insurer must give proper notice to the Applicant and section 44(5)(a) is clear that the Insurer must provide medical reasons. The Applicant argues that the notice is supposed to convey enough information to the unsophisticated Insured so the Applicant knows whether he or she wants to continue with the claimed benefit or not, therefore, an Applicant is not compelled to attend an examination when the notice is non-compliant with the mandatory components of section 44(5)(a).

The Insurer's final letters of notice for the section 44 examinations, dated September 22, 2014, on which the Insurer relies, read in part as follows:

> State Farm has scheduled this examination for the following reasons:
> State Farm has received the Life Care Plan of Alison Meyer dated April 15, 2014 as well as the in home occupational therapy assessment acquired brain injury report of Lindsay Blackwell, Occupational Therapist, dated February 26, 2014 which relate information as to your current physical psychological and cognitive symptoms and impairments. Mr. Ward was last assessed in respect to his entitlement to an income replacement benefit in 2009. The reports of Ms. Meyers and Ms. Blackwell report findings as to your functional limitations and prognosis that appear to be inconsistent with the observations obtained of you in surveillance undertaken between May 21, 2013 and August 10, 2014.
>
> As it has been 5 years since you were last assessed, State Farm seeks an opinion as to the current status of your physical and psychological impairments as a result of the accident and whether you continue to suffer a complete inability to engage in any employment or self-employment for which you are reasonably suited by education, training or experience.

I find a parallel with this case and that of *Augustin and Unifund Assurance Company*, and find myself in agreement with Arbitrator Sapin, where she states the following at page 12, paragraph 4:

> Given the serious consequences to an insured person of refusing to attend an IE for which proper notice has been given - barred from commencing a mediation proceeding to dispute an insurer's denial of medical treatment - the notice requirements set out in s. 44(5) should be strictly construed and the insurer's notice should be closely examined to ensure it complies. The requirements are mandatory. They are there to balance the naturally intrusive nature of an IE and to ensure fairness. The insured person is entitled to make an informed decision about whether they wish to pursue their claims and attend the IE, or not. The legislature has determined that, in fairness, an insured person is entitled to specific information, including medical reasons, about why they are being required to attend an IE.

> I find it would be unreasonable and unfair to require them to attend without first being in possession of that information.

In my view there are two tests which must be met, namely medical and other reasons. The most contentious in this matter is the "medical reasons".

I cannot find any medical reasons contained within the notices. The mere mention of a Life Care Plan and an Occupational Therapist's acquired Brain Injury Report, in itself, does not meet the "medical reasons" test, let alone whether the examinations were reasonable and necessary. In my view, the medical reasons test must tell the Applicant, in an unsophisticated way, why the tests are reasonable and necessary.

For these reasons, I find that the notice is insufficient and that the Insurer cannot rely upon the non-attendance of said examinations. Therefore, I now order that the IRBs claim may proceed to Arbitration.

2. Is the Applicant precluded from proceeding to Arbitration for the claimed transportation expenses?

The Insurer argues that the Applicant has not submitted a treatment plan as requested by the Insurer, pursuant to section 38 of the *SABS*, and by extension, the Applicant has not attended a requested section 44 examination. The Insurer is requesting that this issue be stayed until the Applicant attends a section 44 Insurer Examination *after* submitting a treatment plan for same.

It is uncontested evidence that:

a) The disputed transportation <u>costs</u> relate to treatment with Dr. Billing;
b) The Applicant was referred to Dr. Billing via his family doctor;
c) OHIP is funding the treatment;
d) The transportation expense is sought by way of mileage to the closest hospital that renders the injections;

e) This expense was paid until March 27, 2015, after the Applicant was assessed at the Insurer's request by Dr. Oshidari, a physiatrist, whose report was issued October 27, 2014. In that report, Dr. Oshidari stated he was surprised to learn that the treatment was continuing beyond a few years and that the Applicant appraised his own improvement with the injections to be about 30%;

f) The previous payments for said mileage were being paid under section 15(1)(g) of the *SABS*;

g) The Applicant has provided Dr. Billing's updated clinical notes and records on an ongoing basis to the Insurer.

Section 15(1)(g) reads, as follows:

15. (1) Subject to section 18, medical benefits shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident for,

(g) transportation for the insured person to and from treatment sessions, including transportation for an aide or attendant;

Section 38(2)(c)(ii) reads as follows:

38. (1) This section applies to,

(a) medical and rehabilitation benefits other than benefits payable in accordance with the Minor Injury Guideline; and

(b) all applications for approval of assessments or examinations. O. Reg. 34/10, s. 38 (1).

(2) An insurer is not liable to pay an expense in respect of a medical or rehabilitation benefit or an assessment or examination that was incurred before the insured person submits a treatment and assessment plan that satisfies the requirements of subsection (3) unless,

(a) the insurer gives the insured person a notice under subsection 39 (1) stating that the insurer will pay the expense without a treatment and assessment plan;

> (b) 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; or
>
> (c) the expense is reasonable and necessary as a result of the impairment sustained by the insured person for,
>
> (i) drugs prescribed by a regulated health professional, or
>
> (ii) goods with a cost of $250 or less per item. O. Reg. 34/10, s. 38 (2).

I agree with the Applicant that section 38 does not state that an Applicant is required to submit a treatment plan for treatment for which the Applicant is not requesting payment.

I also agree with the Applicant's argument that section 38(2)(c)(ii) expressly provides that an expense of $250.00 or less per item does not require the Applicant to submit a treatment plan.

I also agree with the Applicant's argument that the *SABS* does not say that the Insurer is only responsible to pay for all approved transportation costs.

I also agree with the Applicant's pleadings that transportation expenses are considered payable through the "virtual" Medical and Rehabilitation Benefits account, and, transportation in and of itself is not a proposed good, service, assessment or examination as contemplated in section 38. It is simply an expense incurred by an insured person as a result of attending the proposed goods, services, assessments and examinations that is reasonably necessary for the insured person's treatment or rehabilitation.

I paraphrase the Applicant's definition of "virtual account" as the pot of money that is created by the Insurer, upon verification of the degree of injury of an Insured. The virtual account is for the payment of all the reasonable and necessary medical and rehabilitation costs, up to the maximum limits as described within the *SABS*, on a case by case basis.

I have not heard evidence that the expenses were unreasonable and unnecessary because they were outside the transportation guidelines, nor did I hear any evidence that the transportation expense for said injections was not as a direct result of the accident.

For these reasons, I find that a treatment plan is not required to be submitted to the Insurer. Thus the section 44 examination request becomes redundant and is not available to the Insurer as a tool to assess the necessity and reasonableness of the transportation expense. Therefore, I find that the Applicant can proceed to Arbitration for the transportation expenses.

3. Is the Applicant precluded from proceeding to Arbitration for the claimed prescription expenses?

The Insurer argues that the Applicant has not submitted a treatment plan as requested by the Insurer, pursuant to section 38 of the *SABS*, and by extension, the Applicant has not attended a requested section 44 examination. The Insurer is requesting that this issue be stayed until the Applicant attends a section 44 Insurer Examination after submitting a treatment plan for same.

The undisputed evidence shows that the Applicant has been claiming $124.05 per month for the prescription drug known as Nabilone, which was prescribed by Dr. Abell to help with back and some stomach upset which results from his other medications, which were a direct result of the motor vehicle accident.

The Insurer relies on Dr. Oshidari's report of October 27, 2014, which suggests that the doctor indicates in passing that the continued use of this drug was not reasonable or necessary. Thus the Insurer requested that a treatment plan under section 38 be submitted and then a section 44 Insurer Examination could review the proposed treatment plan for its necessity and reasonableness.

The Applicant argues that in section 38, a treatment plan for the prescribed drugs, which cost less than $250.00, is exempt from the necessity of rendering a treatment plan for review, thus a section 44 examination could not be requested as section 44 does not stand alone. In other words, section 44 needs a trigger to activate the section, such as section 38 or section 37 of the *SABS*.

In reading section 38(2), I find the exemptions which do not require a treatment plan.
I read section 38(2)(c)(i) and (ii), which reads as follows:

38. (2) An insurer is not liable to pay an expense in respect of a medical or rehabilitation benefit or an assessment or examination that was incurred before the insured person submits a treatment and assessment plan that satisfies the requirements of subsection (3) unless,

(c) the expense is reasonable and necessary as a result of the impairment sustained by the insured person for,

(i) drugs prescribed by a regulated health professional, or

(ii) goods with a cost of $250 or less per item. O. Reg. 34/10, s. 38 (2).

In my view, either one of the two tests is required to be passed in order to qualify the drugs in question to be exempt.

In this case, both tests are passed, as the evidence shows the drug Nabilone was prescribed by a regulated health professional and costs less than $250.00 per item. In my view, the legislature had made the determination that to speed up recovery of an insured person and save costs in the medical and rehabilitation process, streamlining this process needed to be ensured. The regulated health professionals in these circumstances would ensure both the speed of delivery and that the expenses are reasonable and necessary, without the costly expense of engaging in the treatment plan process contemplated in section 38, and also removing the unnecessary invasion of a section 44 assessment.

As the Applicant argued regarding the IRB section 44 examinations, above, the Applicant continues to argue that the notice for this section 44 assessment was insufficient in that it did not provide proper medical reasons for the examination.

I note that the letter containing the reasons for the section 44 examination request is contained in a letter which requires an assessment for the case management treatment plan (OCF-18) and that for the drug Nabilone.

The State Farm letter, dated April 1, 2015, reads, in part as follows:

> Certas Home and Auto Insurance Company has scheduled this examination for the following reasons:
>
> 1) Review of the findings of Dr. Oshidari's S. 44 Physiatry report of 10/27/14 indicates that this OCF-18 does not appear to be reasonable or necessary.
> 2) Review of the findings of Dr. Oshidari's S. 44 Physiatry report of 10/27/14 indicates that the use of this medication does not appear to be reasonable or necessary.

In my view, this notice also fails to give medical or other reasons as required by section 44(5)(a) of the *SABS*. There is only a single reason given for each examination request. It is clear that the word "reasons" as used in section 44(5)(a) is plural, meaning more than one. Further I cannot find in reading the reason given to be a medical reason for the examination.

Finally, the Applicant argues that section 44 of the *SABS* is not a stand-alone section. It needs a trigger to allow the Insurer Examination. In reading the *SABS*, I am instructed by the Applicant that all sections of the *SABS* must have meaning and one section cannot render others meaningless or redundant.

The Applicant argues that State Farm has no right to have the Applicant attend medical assessments or receive confidential medical information from the Applicant unless the specific wording of the *SABS* grants such a right.

If, as State Farm claims, an Insurer could request a section 44 assessment at any time relying on section 44 standing on its own, then there would be no need for the *SABS* to specifically allow

section 44 assessments in sections 36, 37, 38, 42 and 45 as this would render provisions with these sections redundant and unnecessary.

I am directed by the Supreme Court of Canada in *Rizzo and Rizzo Shoes Ltd, (re)*, 1998 CANLII 837 (SCC), at paragraphs 21, 22 and 27, which read in part as follows:

Para. 21

> Although much has been written about the interpretation of legislation (see, e.g., Ruth Sullivan, Statutory Interpretation (1997); Ruth Sullivan, Driedger on the Construction of Statutes (3rd ed. 1994) (hereinafter "Construction of Statutes"); Pierre-André Côté, The Interpretation of Legislation in Canada (2nd ed. 1991)), Elmer Driedger in Construction of Statutes (2nd ed. 1983) best encapsulates the approach upon which I prefer to rely. He recognizes that statutory interpretation cannot be founded on the wording of the legislation alone. At p. 87 he states:
>
> > Today there is only one principle or approach, namely, the words of an Act are to be read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament.

Para. 22

> I also rely upon s. 10 of the Interpretation Act, R.S.O. 1980, c. 219, which provides that every Act "shall be deemed to be remedial" and directs that every Act shall "receive such fair, large and liberal construction and interpretation as will best ensure the attainment of the object of the Act according to its true intent, meaning and spirit".

Para. 27

> …It is a well established principle of statutory interpretation that the legislature does not intend to produce absurd consequences. According to Côté, supra, an interpretation can be considered absurd if it leads to ridiculous or frivolous consequences, if it is extremely unreasonable or inequitable, if it is illogical or incoherent, or if it is incompatible with other provisions or with the object of the legislative enactment (at pp. 378-80). Sullivan

> echoes these comments noting that a label of absurdity can be attached to interpretations which defeat the purpose of a statute or render some aspect of it pointless or futile (Sullivan, Construction of Statutes, supra, at p. 88).

In my opinion, the *Rizzo Shoes* decision provides the framework in which statutory interpretation must be followed, while the *Co-Operators* decision provides the lens that this legislation is to be viewed as consumer protection legislation. With this being said, it is clear that the Ontario legislature provided certain instances where a treatment plan is exempt, thus taking the section 44 assessment tool away from the Insurer. A balancing of competing interests versus personal privacy has already been considered and reached. I accept the Applicant's arguments; to ignore the expressly written exemptions from the other recognized triggers for a section 44 examination would make certain sections of the *SABS* unnecessary or redundant.

For the above reasons, I find that prescription expenses claimed may proceed to Arbitration.

4. Is the Applicant precluded from proceeding to Arbitration for the claimed case management services?

For the case management issue, the Insurer takes the position is that the Arbitration must be stayed until such time that the Applicant attends a section 44 assessment.

The Insurer argues that by virtue of the Applicant's submission of a treatment plan, dated March 2, 2015, where Renew Rehab recommended case management services supported by Dr. Avrum Green, under section 17 of the *SABS*, State Farm has the ability or right to request that the Applicant submit to a section 44 assessment, as the necessity of the plan was not made clear in the Insurer's mind.

The Insurer's position is that section 17 of the *SABS* states that all of section 38 of the *SABS* applies, therefore triggering a section 44 assessment which can be in turn requested by the Insurer.

The Insurer argues that section 14 clearly designates section 17 as a Medical and Rehabilitation Benefit, therefore, the words "reasonable and necessary" may be tested by the Insurer, under section 44, at their request.

Section 14 of the *SABS* reads as follows:

PART III

MEDICAL, REHABILITATION AND ATTENDANT CARE BENEFITS

Insurer liable to pay benefits

14. Except as otherwise provided in this Regulation, an insurer is liable to pay the following benefits to or on behalf of an insured person who sustains an impairment as a result of an accident:

    1. Medical and rehabilitation benefits under sections 15 to 17.

    2. If the impairment is not a minor injury, attendant care benefits under section 19. O. Reg. 34/10, s. 14.

Section 17 of the *SABS* reads as follows:

17. (1) Subject to subsection (2), medical or rehabilitation benefits shall pay for all reasonable and necessary expenses incurred by or on behalf of an insured person as a result of the accident for services provided by a qualified case manager in accordance with a treatment and assessment plan under section 38,

    (a) if the insured person sustains a catastrophic impairment as a result of the accident; or

    (b) if the optional medical, rehabilitation and attendant care benefit referred to in paragraph 5 of subsection 28 (1) is available to the insured person. O. Reg. 34/10, s. 17 (1).

(2) The insurer is not liable to pay expenses for case manager services that exceed the maximum rate or amount of expenses established under the Guidelines. O. Reg. 34/10, s. 17 (2).

(3) In this section,

"qualified case manager" means a person who provides services related to the co-ordination of goods or services for which payment is provided by a medical, rehabilitation or attendant care benefit. O. Reg. 34/10, s. 17 (3); O. Reg. 289/10, s. 3. [Underline added for emphasis.]

I accept the Applicant's interpretation of section 14 that the "virtual account" called medical and rehabilitation benefits shall pay for the specified benefits listed in sections 15, 16 and 17. It does not mean, however, that section 17's case manager benefit is in fact a Medical or Rehabilitation Benefit, *per se*. The legislature severed the case manager because it is not a specified Medical or Rehabilitation Benefit. The case manager's function is to coordinate the specified benefits of sections 15 and 16 in order help the insured person to attend and claim said specified Medical/Rehabilitation and/or Attendant Care Benefits for a catastrophically impaired person.

In my view, the plain and ordinary reading of section 17 consists of two components: the first is substantive and the second is procedural.

It is clear that section 17 reads as a mandatory payment section where the legislature uses the words "*shall pay*" for benefits that are "*reasonable and necessary expenses incurred by or on behalf of an insured person as a result of the accident for services provided by a qualified case manager*".

The second part is procedural, where the Applicant must submit a treatment plan in "*accordance*" with section 38. In my opinion, this allows for a harmonious continuity of treatment plan writing and communications between the service providers and the Insurer. I note that section 38(3) is the subsection that defines what needs to be contained within a treatment plan. This does not mean that all of section 38 applies, as the Insurer submits. In my view, if the legislature wanted all of section 38 to apply, it would have used express language for same, clearly it did not. This makes

sense if we remind ourselves that the legislature has taken into account that a catastrophically impaired person may have already gone through a complete battery of multidisciplinary assessments by the Insurer via section 44(1), which reads as follows:

> 44. (1) For the purposes of assisting an insurer to determine if an insured person is or continues to be entitled to a benefit under this Regulation for which an application is made, but not more often than is reasonably necessary, an insurer may require an insured person to be examined under this section by one or more persons chosen by the insurer who are regulated health professionals or who have expertise in vocational rehabilitation. O. Reg. 34/10, s. 44 (1). [Underline added for emphasis.]

The balancing act between the competing interests and personal privacy has been considered and found, in that further section 44 assessments of a catastrophically impaired person for this benefit would be unreasonable. In my view, this is another reason why section 17 is separate and distinct from sections 15 and 16 of the *SABS*. Section 17 is a benefit but not a specified benefit subject to section 44 assessments. In the instant case, I note that the evidence is overwhelming that the Insurer had a large number of section 25 and 44 assessments in its possession at the time it requested yet another section 44 assessment for the case manager benefit.

There is no evidence before me that suggests that the Applicant failed the procedural segment of this section. Nor is there any evidence that the plan presented was unreasonable in that the fee for the service was out of line for the service provider and the guidelines which regulate same.

The Applicant, however, continues to argue that if it was allowed that a section 44 assessment was appropriate in this case, then the notification letter, dated April 1, 2015, *supra*, must provide under section 44(5)(a), the same "medical and other reasons" as was argued previously in question #3 of this Preliminary Issue Hearing. The Applicant maintains that the notice had no medical reasons contained within it and therefore should be found to be insufficient in satisfying the Insurer's statutory obligations, thus the Applicant is allowed to proceed with this issue to Arbitration.

In reading the reasons given in the section 44 notice letter, I must repeat myself with my previous findings that, in my view, this notice also fails to give medical or other reasons as required by section 44(5)(a) of the *SABS*. There is only a single reason given for the examination request. It is clear that word "reasons" is plural, meaning more than one. Further, I cannot find in reading the reason given that it could be considered to be a medical reason for the examination.

For these reasons, I now find that the case management services claimed may proceed to Arbitration.

EXPENSES:

The parties made no submissions on expenses. If the parties are unable to agree on the entitlement to, or 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*.

	January 15, 2016
Chuck Matheson Arbitrator	Date

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

FSCO A14-010161

BETWEEN:

LARRY WARD

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. Income Replacement Benefits claimed may proceed to Arbitration.
2. Transportation expenses claimed may proceed to Arbitration.
3. Prescription expenses claimed may proceed to Arbitration.
4. Case management services claimed may proceed to Arbitration.
5. If the parties are unable to agree on the entitlement to, or 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*.

Chuck Matheson
Arbitrator

January 15, 2016
Date