Citation: **N. M. vs. Aviva Insurance Canada, 2019** ONLAT **17-007986/AABS**

Date: February 7, 2019
File Number: 17-007986/AABS

In the matter of an Application pursuant to subsection 280(2) of the *Insurance Act*, RSO 1990, c I.8., in relation to statutory accident benefits.

Between:

N. M.

Appellant(s)

and

Aviva General Insurance

Respondent

DECISION

ADJUDICATOR: **Christopher A. Ferguson**

APPEARANCES:

For the Appellant: Olga Kanevsky, Paralegal

For the Respondent: Geoffrey L. Keating, Counsel

HEARD: In Writing **Hearing: May 22, 2018**

OVERVIEW

[1] The applicant "N.M." was involved in a motor vehicle accident ("the accident") on September 14, 2015 and sought benefits pursuant to the *Statutory Accident Benefits Schedule – Effective September 1, 2010*[1] ("the *Schedule*").

[2] N.M. applied to the Licence Appeal Tribunal (the "Tribunal") when his claims for benefits were denied by the respondent "Aviva".

ISSUES IN DISPUTE

[3] I must determine the following issues:

1. Is N.M. entitled to a medical and rehabilitation benefit in the amount of $2,661.57 for physiotherapy treatment recommended by East Sheppard Rehab in a treatment plan (OCF-18) submitted on July 21, 2017, and denied on July 26, 2017?

2. Is N.M. entitled to interest on any overdue payment of benefits?

3. Is Aviva liable to pay N.M. an award under *Regulation 664, Automobile* Insurance[2] ("Regulation 664") because it unreasonably withheld or delayed payments to him/her?

RESULT

[4] I find that N.M. has not met the onus on him to prove that the medical benefit he seeks is reasonable and necessary.

[5] Aviva is not liable to pay N.M. an award.

REASONS & ANALYSIS

[6] Sections 14 and 15 of the *Schedule* provide that an insurer is only liable to pay for medical expenses that are reasonable and necessary as a result of the accident. The applicant bears the onus of proving on a balance of probabilities that any proposed treatment or assessment plan is reasonable and necessary.[3]

[7] N.M.'s submissions provide no argument or analysis related to his medical evidence to guide me in assessing whether or not the medical benefit he claims is reasonable and necessary. His submissions include medical information that is not clearly related to or relevant to the accident.

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[1] O. Reg. 34/10.

[2] i.e. s.10, Regulation 664, R.R.O. 1990, *Insurance Act*

[3] *Scarlett v. Belair,* 2015 ONSC 3635

[8] N.M. submits that "the Respondent has not met the standard of claim adjustment. As such, the applicant request [sic] that the Respondent approves the OCF-18 Treatment and Assessment Plan dated July 21, 2017."

[9] N.M.'s assertion that Aviva mismanaged his claim is based on a delay of seven months between the date of the OCF-18 and the insurer's examination (IE) conducted by Dr. Todd Walters, Family Medicine. N.M. also asserts that Dr. Walter's findings are undermined by this delay, since his medical condition had improved as a result of treatment; as a result, Dr. Walters could not have been able determine whether or not the OCF-18 was reasonable and necessary at the time it was submitted.

[10] Aviva contends that N.M. has simply failed to lead any evidence or argument to establish that the disputed treatment plan is reasonable and necessary and, therefore, his claim cannot succeed.

[11] In addition, Aviva relies on its insurer's examination (IE) report, dated February 14, 2018, by Dr. Todd Walters, Family Medicine, in which Dr. Walters concludes that the disputed treatment plan was not reasonable and necessary.

[12] In find that N.M. has failed to meet the onus on him to show that the disputed benefit was reasonable and necessary. My reasons are:

i. N.M. provides no medical basis for concluding that the claimed benefit is reasonable and necessary. His submission is silent on the medical reasons given by Aviva[4] for denying his claim, which included concerns about frequency of care over time and over-emphasis on passive treatment without an active rehabilitative phase.

ii. N.M. provides me with no legal authority or precedent for allowing an appeal of a specific medical benefit on the basis of sub-standard claims adjustment. I do not believe that I have the authority to make such a decision.

iii. N.M.'s criticism of Dr. Walter's IE findings is irrelevant in the absence of positive evidence to support his claim. Weaknesses in an insurer's rebuttal to a claim do not prove the claim.

AWARD

[13] Section 10 of Regulation 664 permits the Tribunal to award a lump sum of up to 50% of the amount to which the insured person (i.e. the applicant) was entitled at the time of the award together with interest on all amounts then owing

[4] In its letter to him dated January 4, 2018.

(including unpaid interest) if it finds that that an insurer (i.e. the respondent) has "unreasonably" withheld or delayed payments.

[14] Because an award is premised on an amount to which the applicant is entitled, my finding that N.M. has failed to prove his entitlement to the claimed benefit renders his award application moot.

[15] I do note, however, that N.M. fails to reply to Aviva's account of why its IE was delayed. According to Aviva, the delay in scheduling the IE arose from N.M.'s delay in providing medical records necessary to proceed.

INTEREST

[16] Section 51 of the *Schedule* sets out the criteria for assessing and awarding interest on overdue payments.

[17] The benefits claimed by the applicant are denied and therefore, no interest on overdue payments is due.

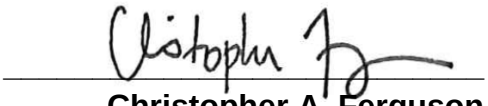
CONCLUSION

[18] N.M. has not met the onus on him to prove his entitlement to the disputed treatment plan.

[19] N.M.'s claim for an award is without merit and is dismissed.

[20] There are no payments owing to N.M. and therefore no interest due on overdue payments.

Released: February 7, 2019



Christopher A. Ferguson
Adjudicator