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

Citation: Marika Hippolyte vs. Aviva General Insurance Company, 2020 ONLAT 19-006962/AABS

Released Date: 09/25/2020
File Number: 19-006962/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:

Marika Hippolyte

Applicant

and

Aviva General Insurance Company

Respondent

DECISION

ADJUDICATOR: **Rebecca Hines**

APPEARANCES:

For the Applicant: Darcie Sherman, Counsel

For the Respondent: Jennifer Cosentino, Counsel

HEARD: **By way of written submissions**

OVERVIEW

[1] Marika Hippolyte (the “applicant”) was involved in an automobile accident on February 12, 2017, and sought benefits from Aviva General Insurance Company (the “respondent’) pursuant to the Statutory Accident Benefits Schedule - Effective September 1, 2010 (the "Schedule"). The applicant was denied certain benefits by the respondent and submitted an application to the Licence Appeal Tribunal - Automobile Accident Benefits Service (“Tribunal”).

[2] The parties participated in a case conference but were unable to resolve the issues in dispute. The matter proceeded to this written hearing.

ISSUES IN DISPUTE

[3] I have been asked to decide the following issues:

i. Is the applicant entitled to a cost of examination in the amount of $2,000.00 for a psychological assessment, recommended by Injury Management and Medical Assessment Clinic (“Injury Management”) in a treatment plan dated April 4, 2017, and denied by the respondent on September 18, 2017?

ii. Is the applicant entitled to a cost of examination in the amount of $2,144.93 for a psychological assessment, recommended by Oshawa Physiotherapy and Rehabilitation Centre (“Oshawa Physiotherapy”) in a treatment plan dated September 5, 2017, and denied by the respondent on September 18, 2017?

iii. Is the applicant entitled to a cost of examination in the amount of $2,200.00 for a physiatry assessment, recommended by Neuro-Rehab Services Inc. in a treatment plan dated September 5, 2017 and denied by the respondent on April 25, 2018?[1]

iv. Is the respondent liable to pay an award under Regulation 664 because it unreasonably withheld or delayed payments to the applicant; and

v. Is the applicant entitled to interest on any overdue payment of benefits?

[1] There were four additional issues in dispute outlined in the Tribunal’s order. The applicant withdrew issues i. ii. iii and v. outlined in the Tribunal’s case conference report and order dated February 4, 2020. In her submissions the applicant incorrectly identified issue iii. as an occupational therapy rehab needs assessment. The Tribunal’s order identified the issue as a “physiatry assessment” so I have listed the issue accordingly.

RESULT

[4] After reviewing the submissions and evidence submitted by both parties, I find the applicant is not entitled to any of the disputed treatment plans for cost of examination expenses, interest or an award.

ANALYSIS

Is the applicant entitled to payment for either of the cost of examinations for psychological assessments recommended by Injury Management and Oshawa Physiotherapy?

[5] The applicant is not entitled to payment of either of the psychological assessments in dispute for the following reasons.

[6] Section 15 of the *Schedule* provides that an insurer is only liable to pay for expenses that are reasonable and necessary as a result of the accident.

[7] Section 25(1)3 of the *Schedule* provides that the insurer shall pay reasonable fees charged by a health practitioner for reviewing and approving a treatment and assessment plan under section 28, including any assessment or examination necessary for that purpose. Section 25(1)5 provides that an insurer shall not pay more than $2,000.00 for conducting any one assessment. The applicant bears the onus of proving on a balance of probabilities that any claimed expenses are reasonable and necessary.

[8] The applicant's submissions and evidence fell short of meeting her onus in proving entitlement to the claimed psychological assessments. The applicant provided a summary of her post-accident medical impairments but failed to address the particulars of each of the disputed treatment plans. In addition, she did not submit the treatment plans in dispute or refer to the evidence that she relies upon to support that same are reasonable and necessary as a result of her accident related impairments. However, this is the test that must be met. The applicant also submitted caselaw which was not helpful as she failed to articulate how the facts outlined in those decisions are relevant to the present case. Upon review of same it was not apparent to this writer. Therefore, the applicant's claims for these costs of examinations fail. However, for clarity I find it important to highlight the respondent's submissions in relation to these issues as it provided context with respect to the benefits in dispute.

[9] The respondent submitted the treatment plans for the psychological assessments for the Tribunal's consideration. The respondent maintains that the applicant

submitted three separate treatment plans from three different service providers for a psychological assessment around the same time. The following treatment plans confirm this fact:

a. On April 20, 2017 the applicant submitted a treatment plan for a psychological assessment recommended by Leanne Wagner at Injury Management and Medical Assessment Clinic;

b. On April 25, 2017, the applicant submitted a second treatment plan for a psychological assessment recommended by Dr. Fiati; and

c. On September 11, 2017, the applicant submitted a third treatment plan for a psychological assessment recommended by Dr. Pilowsky at Oshawa Physiotherapy and Rehabilitation Center;

[10] The goals of all three treatment plans are to assess and evaluate the applicant's accident related psychological symptoms. In response to the first treatment plan, the respondent arranged a psychological insurer examination ("IE") and notified the applicant that an IE would take place on October 11, 2017. An IE was conducted by Dr. MacKay, psychologist who determined that a psychological assessment was reasonable and necessary.

[11] On November 7, 2017, the respondent sent three letters along with a copy of the IE of Dr. Mackay to the applicant indicating that it had determined that a psychological assessment was reasonable and necessary. In its letter the adjuster requested counsel for the applicant to contact them to discuss treatment as three different services providers had submitted treatment plans which is obviously a duplication of service. The applicant never responded to the respondent's request.

[12] The psychological assessment of Dr. Fiati was originally included as an issue in dispute for this written hearing. The respondent was not aware that the applicant had incurred the psychological assessment of Dr. Fiati until it was served with the applicant's productions for this written hearing on April 29, 2020. This was two months after the case conference occurred. Upon receiving this information, the respondent issued payment for the incurred assessment and the applicant withdrew the assessment of Dr. Fiati as an issue in dispute. The respondent submits that the two psychological assessments listed as issues in dispute are a duplication of services. I agree.

[13] The applicant chose not to file reply submissions addressing the concerns raised by the respondent. In her initial submissions, the applicant provided a summary

of the findings of Dr. Fiati's assessment and submits that this proves that the applicant requires ongoing treatment. However, a treatment plan for psychological treatment is not dispute. I find the applicant provided no argument as to why the two treatment plans for psychological assessments are reasonable and necessary. In the absence of a reasonable explanation and based upon the evidence before me, I agree with the respondent and do not find the two psychological assessments reasonable and necessary.

[14] The applicant has not met her onus in proving on a balance of probabilities that these two disputed treatment plans are reasonable and necessary as a result of her accident related impairments.

Is the applicant entitled to the physiatry assessment in the amount of $2,200.00 recommended by Neuro Rehab Services Inc.?

[15] The applicant is not entitled to payment of the physiatry assessment for the following reasons.

[16] Section 280(4) of the *Insurance Act* provides that a dispute shall be resolved in accordance with the *Schedule.* In order for a dispute to arise s.38 requires that a treatment plan (OCF-18) be submitted to the insurance company for consideration. Without the submission of a treatment plan to the insurer and denial by the insurer there is no dispute.

[17] The respondent argues that prior to filing her application with the Tribunal the applicant had not submitted a treatment plan for either an occupational therapy rehab needs assessment or a physiatry assessment through the Health Claims for Auto Insurance (HCAI) database[2].

[18] To provide some background, a case conference was held on February 4, 2020 and a written hearing was scheduled for July 2020 and the applicant was provided with a deadline of June 8, 2020 to file her submissions. The respondent maintains that on May 23, 2020 the applicant submitted a treatment plan for a total body assessment (also known as a physiatry assessment) in the amount of $2,200.00, through HCAI. However, it did not deny this treatment plan until June 10, 2020, which was two days after the applicant's submissions were due for this written hearing. Therefore, the respondent maintains that the applicant is statute barred from raising this as an issue as the Tribunal does not have jurisdiction to

[2] The electronic database for submitting auto insurance claims forms between insurers and health care facilities in Ontario.

determine an issue that was not denied prior to the applicant filing an application with the Tribunal. I agree with the respondent.

[19] The applicant was provided with the opportunity to file reply submissions in response to the issues raised by the respondent, however, chose not to. In her initial submissions the applicant did not specifically refer to this treatment plan, nor did she submit it as part of her document brief or direct me to any evidence in support of the fact that it is reasonable and necessary. In her submissions she maintains that she suffers from chronic pain, amongst several other medical conditions. However, she does not link her medical condition to the examination being sought or provide any analysis for why it is reasonable and necessary. In addition, she did not submit any evidence that this treatment plan was submitted to the respondent or denied prior to filing her application with the Tribunal.

[20] I find that the Tribunal does not have jurisdiction to determine whether or not the treatment plan is reasonable and necessary as there is no evidence before me that the treatment plan was submitted or denied prior to the applicant filing her application with the Tribunal. Therefore, there is no issue in dispute to be decided by the Tribunal.

Is the applicant entitled to payment of interest on overdue payment of benefits?

[21] The applicant is not entitled to interest.

[22] Section 51(1) of the Schedule provides that “an amount payable in respect of a benefit is overdue if the insurer fails to pay the benefit within the time required under this regulation.”

[23] Since I do not find that any payments are overdue the applicant is not entitled to interest.

Is the respondent liable to pay an award under Regulation 664 because it unreasonably withheld or delayed payments to the applicant?

[24] The applicant is not entitled to an award.

[25] Section 10 of Regulation 664 speaks to an award. Specifically, if the Licence Appeal Tribunal finds that an insurer has unreasonably withheld or delayed payments, the Licence Appeal Tribunal, in addition to awarding the benefits and interest to which an insured person is entitled under the Statutory Accident Benefits Schedule, may award a lump sum of up to 50 per cent of the amount to which the person was entitled at the time of the award together with interest on all amounts then owing to the insured (including unpaid interest) at the rate of 2

per cent per month, compounded monthly, from the time the benefits first became payable under the Schedule.

[26] The applicant argues that she is entitled to an award because the respondent unreasonably withheld and delayed payment of her accident benefits. The applicant failed to establish this fact.

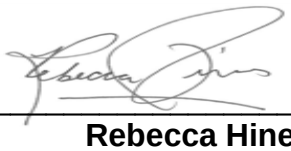
[27] Since I have determined that the treatment plans in dispute are not reasonable and necessary an award is not warranted in this case as I do not find the respondent unreasonably withheld or delayed payments of any benefits.

ORDER

[28] For all of the above reasons, the applicant is not entitled to the disputed treatment plans, interest or an award.

[29] The application is dismissed.

Released: September 25, 2020



Rebecca Hines
Adjudicator