Citation: A.H. v. Aviva Insurance Canada, 2021 ONLAT 19-004639/AABS

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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:

[A.H.]

Applicant

and

Aviva Insurance Canada

Respondent

DECISION

ADJUDICATOR:	**Theresa McGee, Vice-Chair**
APPEARANCES:	
For the Applicant:	[A.H.], Applicant Kashif Ali, Paralegal Asima Ridwan, Paralegal (observing)
For the Respondent:	Harkirat Sharda, Adjuster Geoffrey Keating, Counsel
Interpreter	Abdul Hashim (Bengali Language)
Court Reporter:	Guido Riccioni
HEARD: by Videoconference:	**May 17 and 18, 2021**

REASONS FOR DECISION

OVERVIEW

[1] The applicant, [A.H.], was involved in an automobile accident on September 8, 2015, and sought benefits from the respondent, Aviva Insurance Canada, pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010*[1] ("*Schedule*").

[2] The respondent denied certain benefits claimed by the applicant. The applicant then applied to the Licence Appeal Tribunal ("Tribunal") for resolution of the dispute.

ISSUES

[3] The issues to be decided in the hearing are:

a. Is the applicant entitled to an income replacement benefit in the amount of $331.15 from October 26, 2016 to date and ongoing, submitted on April 20, 2017, denied by the respondent on May 17, 2017?

b. Is the applicant entitled to a medical and rehabilitation benefit in the amount of $2,479.38 for chiropractic treatment recommended by Toronto Healthcare Clinic Inc. in a treatment plan (OCF-18) dated May 23, 2019, submitted on May 24, 2019 and denied on June 19, 2019?

c. Is the applicant entitled to a medical and rehabilitation benefit in the amount of $1,529.51 for chiropractic treatment recommended by Toronto Healthcare Clinic Inc. in a treatment plan (OCF-18) dated August 28, 2019, submitted on August 29, 2019 and denied on September 12, 2019?

d. Is the applicant entitled to a medical and rehabilitation benefit in the amount of $2000.00 for other goods and services recommended by Toronto Healthcare Clinic Inc. in a treatment plan (OCF-18) submitted on July 6, 2019 and denied on July 29, 2019?

e. Is the applicant entitled to a medical and rehabilitation benefit in the amount of $200.00 for other goods and services recommended by Toronto Healthcare Clinic Inc. in a treatment plan (OCF-18) denied on May 29, 2019?

[1] O. Reg. 34/10.

f. Is the applicant entitled to the cost of an examination in the amount of $2,409.16 for the preparation of an income replacement benefit report recommended by RSM Canada Consulting LD, in a treatment plan (OCF-18) dated March 2, 2020 and denied on March 17, 2020?

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

RESULT

[4] The applicant has not met his onus of establishing entitlement to the income replacement and medical benefits he seeks. No interest is owing. The application is dismissed.

ANALYSIS

Is the applicant entitled to an income replacement benefit?

The applicant has not met the test for disability

[5] Section 5(1)1.i. of the *Schedule* establishes the eligibility criteria for an income replacement benefit for a person who, like the applicant, was employed at the time of the accident. To be entitled to the benefit, the applicant must prove on a balance of probabilities that he sustained an impairment as a result of and within 104 weeks of the accident, and that the impairment caused a substantial inability to perform the essential tasks of his pre-accident employment.

[6] The applicant was over the age of 65 at the time of the accident. Section 9(1)(b)of the *Schedule* provides that if a person becomes entitled to an income replacement benefit on or after their 65th birthday, they will only be entitled to an income replacement benefit for a maximum of 208 weeks (or four years) after becoming entitled.

[7] There is no dispute that the applicant returned to work after the accident. He continued to work for over a year until October 2016, when the residential building where he collected rent from tenants was sold. The applicant submits that he stopped working in part because of the sale of the business, but also because of his physical condition. He testified that he felt weak and uncomfortable while at work, took longer to complete tasks because of discomfort, and had difficulty concentrating.

[8] The applicant testified that after his October 2016 work stoppage, he was not physically or mentally fit to find another job. He testified that movement was difficult, and that he had no energy. When asked under direct examination

whether his condition was the only reason he did not work after October 2016, he answered that it was.

[9] The applicant was cross-examined on his employment history. Initially, he testified that he has not worked since October 2016. When asked to explain the nature of the business income he claimed on his 2017 tax return, the applicant conceded that he had in fact returned to work in 2017. He testified that he had no other option than to do so because his situation was not good. He testified that he had applied for employment insurance but did not get it. When cross-examined, the applicant gave evidence that he returned to his previous employer and did some work, collecting rent from tenants like his previous job, but that he could not remember when in 2017 he began working or how much income he earned that year. He testified that he stopped working in September 2017 because his physical situation had worsened, and that he traveled to [abroad] in November 2017 to visit an ill relative where he did not perform work of any kind. When asked whether he had been planning his trip to [abroad] as early as August 2017, and whether his planned trip had anything to do with his work stoppage, the applicant answered that it had. The applicant gave evidence that he spent time in [abroad] in 2017, 2018, and 2019.

[10] I find that the applicant has failed to discharge his evidentiary onus. He has failed to establish that he suffered a substantial inability to perform the essential tasks of employment as a result of the accident. He does not dispute that he worked for over a year after the accident. He gave evidence that he worked through discomfort and weakness, but his evidence demonstrates that he was substantially able to perform the essential tasks of his employment, which he described as data entry and banking duties associated with collecting rent from tenants. The applicant testified that his supervisor permitted him to take his time in doing his work, but he has tendered no employment records to substantiate any modified duties, reduced hours, or other workplace accommodations resulting from any accident-related impairments.

[11] I find on a balance of probabilities that the sale of the business precipitated the applicant's work stoppage in October 2016. The applicant's evidence that he stopped working due to an accident-related impairment is unpersuasive. His testimony is that he worked uninterrupted for over a year after the accident until his employer sold the residential building in which he worked. The applicant has tendered no evidence to corroborate his testimony that an accident-related impairment caused his work stoppage in 2016.

[12] The applicant's testimony about his employment status after October 2016 raises significant doubt as to his credibility. Under oath, he denied working at any time since 2016. It was only when cross-examined about his business income in 2017 that he admitted to working that year. The inconsistency in the applicant's testimony highlights another difficulty with his evidence: he has presented no records capable of corroborating the nature or period of his employment.

[13] The applicant submits that his employment file is irrelevant to the issues in dispute because under s. 9(2) of the *Schedule*, an insurer is not entitled to make deductions for post-accident income when an insured person's entitlement to an income replacement benefit arises after his 65th birthday. I disagree that employment records are irrelevant to this dispute. The dates and nature of the applicant's post-accident employment, as well as any workplace accommodations or modifications he may have required, would typically be confirmed in employment records. These are factual matters directly relevant to whether the applicant meets the requisite disability test. I need not draw an adverse inference from the absence of the employment file, as the respondent asks me to do. This is a question of onus. It is the applicant's onus to establish entitlement to benefits under the *Schedule*. On the whole of the evidence before me, I find the applicant has fallen far short of meeting his burden. I am unable to find that he meets the test for disability under s. 5 of the *Schedule* for any part of the period in dispute.

Compliance with the Schedule

[14] In his submissions, the applicant conceded that he only submitted a disability certificate (OCF-3) indicating entitlement to an income replacement benefit on May 24, 2017, and that under s. 36 of the *Schedule*, his entitlement to the benefit began on that date.

[15] In response to the May 24, 2017 disability certificate, the respondent sent the applicant an Explanation of Benefits dated June 1, 2017. It advised the applicant that the disability certificate indicated he may be eligible for either an income replacement benefit or a non-earner benefit. The respondent notified the applicant of his obligation to submit a completed Election of Benefits (OCF-10) form within 30 days.

[16] The applicant submits that the respondent failed to request insurer's examinations in relation to his income replacement benefit claim within 10 business days of receiving the May 24, 2017 disability certificate as prescribed by s. 36(4) of the *Schedule*. The applicant submits that under s. 36(6), the

respondent must pay the benefit from May 24, 2017 until October 30, 2017, the date it properly requested the insurer's examinations.

[17] The respondent submits that the issue of its non-compliance with s. 36 is moot because for the period of asserted non-compliance, the applicant was not entitled to the benefit as he was working.

[18] I do not accept the respondent's argument that non-compliance with s. 36 is irrelevant when an applicant has no underlying entitlement to a specified benefit. Section 36(6) is a clear shall-pay provision. However, I cannot find that the respondent is obligated to pay the applicant the income replacement benefit he claims for the period of the respondent's non-compliance. This is because the applicant's own non-compliance with the *Schedule* means that s. 36(6) was never engaged.

[19] The applicant's, not the respondent's non-compliance with the *Schedule* is determinative in this case. The June 1, 2017 Explanation of Benefits contained a Notice of Election. It was made within 10 days of receipt of the disability certificate. The applicant submits that he did not comply with the Notice of Election because he felt the request was unreasonable and he did not have to follow up. He had already filed an Employer's Confirmation Form (OCF-2), which he submits showed that he was pursuing an income replacement benefit.

[20] I find as a fact that the documents filed by the applicant in support of his claim created ambiguity as to which specified benefit the applicant was entitled to. It is still possible to qualify for a non-earner benefit if working at the time of the accident, and the May 24, 2017 disability certificate (OCF-3) indicated that the applicant met the disability test for both benefits. The Employer's Confirmation Form (OCF-2) does not eliminate this ambiguity, and it does not stand in the place of a proper election of benefits. The reason the applicant did not comply with the request for an election was, as he submits, that he did not feel the request was reasonable. The applicant's feelings about the reasonableness of a request made pursuant to the *Schedule* are not a justification for non-compliance.

[21] Section 35 of the *Schedule* requires an insured person to elect the benefit they wish to receive within 30 days of receiving a notice of election. Election of benefits is a statutory requirement. The language of s. 35 is mandatory and unambiguous. Failure to complete this step renders an application for a specified benefit incomplete. The applicant failed to comply with a request under s. 35 and has therefore not completed his application for this benefit. The applicant's failure to elect a specified benefit means that the respondent's obligations under

s. 36 were never triggered. Although the respondent did not raise the defence that the income replacement benefit application was never completed, the applicant has squarely raised the issue of the respondent's compliance with the *Schedule*. Both parties made submissions on the procedural history of the claim. I cannot make an order for payment of a benefit that, on the facts before me, has not properly been applied for.

[22] The applicant has failed to establish substantive entitlement to an income replacement benefit due to the requisite disability. He has also failed to establish entitlement arising from any non-compliance with s. 36 of the *Schedule* on the part of the respondent.

Is the applicant entitled to medical benefits?

Chiropractic treatment

[23] The applicant claims two treatment and assessment plans (OCF-18s) for chiropractic treatment (issues b. and c. in para. 3 above). The first disputed treatment plan is dated May 23, 2019 and the second is dated August 28, 2019. Both plans were submitted between three and a half and four years after the accident. The applicant submits that the records of Dr. Giancola, his family physician, show that he was receiving treatment for his right shoulder and knee since the accident. Instead, the records show injuries with questionable links to the accident, including a rotator cuff tear with symptom onset in 2017, and degenerative osteoarthritic changes to the knee.

[24] I do not find evidence of continuous treatment for shoulder and knee injuries since the accident in Dr. Giancola's records. There are few records before me for the period from the date of the accident to early 2017.

[25] It appears from the evidence before me that the accident did not cause the applicant's rotator cuff tear, documented in an x-ray dated February 28, 2017. In a February 24, 2017 letter to Dr. Giancola, Dr. Emily Tam documents the onset of pain in the applicant's right shoulder, which, she notes, arose spontaneously, without a history of trauma, two weeks prior. The onset of shoulder pain and the noted absence of trauma are not consistent with an accident-related injury.

[26] In an assessment at Toronto Rehab on August 30, 2017, the applicant did report that he had right shoulder pain that started after the accident, but he also reported that it resolved after a few months with physiotherapy. An x-ray conducted that same day confirmed the rotator cuff tear, but it also confirmed degenerative osteoarthritis.

[27] The applicant submits that he has had right shoulder pain continuously since the accident. But even the disability certificates submitted by the applicant during the life of his claim suggest that the rotator cuff injury emerged much later than the accident. In the first post-accident disability certificate, dated October 14, 2015, no injuries to the shoulder whatsoever are listed. It is not until May 24, 2017, two months after the applicant reported right shoulder pain to Dr. Tam and the rotator cuff tear was confirmed by diagnostic imaging, that an injury to the muscles and tendons of the rotator cuff of the shoulder appears in a disability certificate.

[28] The applicant has not shown on a balanced of probabilities that his rotator cuff injury required physical therapy as a result of the accident.

[29] I turn now to the applicant's knee condition. The medical records show that in August 2018, Dr. Tam advised the applicant that his knee pain was caused by osteoarthritis. This is a degenerative condition and I find no basis upon which to link it to the accident. Also in 2018, the applicant's care providers at Physiotherapy Associates noted that the applicant was diagnosed with degenerative disc disease.

[30] The applicant has tendered a report by Dr. T. Getahun, Orthopedic Surgeon, in support of his claims. That report was issued on October 30, 2019, after the applicant submitted the disputed treatment plans. I give limited evidentiary weight to Dr. Getahun's report. Dr. Getahun conducted only a partial review of the medical records dating back to the accident. He examined only the disability certificate dated May 29, 2019 and failed to compare this with the two prior disability certificates to analyze the change in the injuries attributed to the accident. He states that he reviewed the medical records of Dr. Tam but does not comment on the finding of a rotator cuff tear confirmed by x-rays ordered by Dr. Tam in February and August 2017 when recommending diagnostic imaging to rule out this same injury. Dr. Getahun concludes that the injuries he lists are a direct result of the accident and does not acknowledge other possible causes of those injuries, even though he notes elsewhere in his report the degenerative changes documented by the applicant's family physician in 2018. Given the passage of time since the accident, Dr. Getahun's failure to engage in a causation analysis rooted in a comprehensive review of the available medical records undermines the force of his conclusions.

[31] To conclude, the applicant has not met his onus in establishing the reasonableness and necessity of the claimed treatment as required under s. 15 of the *Schedule*. The plans were submitted nearly four years post-accident, and the contemporaneous objective medical evidence tends to show that the

applicant's pain complaints at that time were unrelated to the accident. Degenerative osteoarthritic changes and an unrelated rotator cuff injury dominate the medical records, while records show instead that the applicant's accident-related soft tissue injuries resolved with physiotherapy within months of the accident. There is simply no evidentiary link to show that the claimed treatments are reasonable and necessary as a result of an accident four years prior. I need not consider the evidence from the respondent's insurer's examination reports to decide that the plans are not payable.

Psychological Assessment

[32] The applicant seeks the cost of a Psychological Assessment (issues d. and e. in para. 3 above). The respondent submits that it approved the Psychological Assessment, but that it is awaiting the clinic's response to its request under s. 33 of the *Schedule* for more information about how and by whom the assessment was conducted.

[33] The report from the Psychological Assessment lists two authors, Dr. Shaul, a qualified clinical psychologist, and Ms. Ilios, a psychotherapist. It does not specify the division of responsibilities between Dr. Shaul and Ms. Ilios. On February 25, 2020, the respondent wrote to Dr. Shaul requesting documentation including supervisory and billing records. As evidenced by a chain of emails tendered by the respondent, Dr. Shaul's office provided general information about the process it follows in completing an assessment, but it did not respond to the respondent's specific inquiry as to how much time Ms. Ilios and Dr. Shaul spent, respectively, in preparing the report.

[34] A clear statement on the number of hours billed by each of the report's authors is critical for an evaluation of the reasonableness of the expense, as the respondent argues, because a psychotherapist is entitled to a lower hourly rate than a clinical psychologist. Also crucial to an understanding of the reasonableness and necessity of the report is transparent disclosure of the supervisory relationship between Dr. Shaul and Ms. Ilios. The report does not provide this disclosure. The emails exchanged between the respondent and Dr. Shaul's office suggest that Dr. Shaul's involvement in the assessment was limited to reviewing the report and finalizing the diagnosis. Absent further information, I can only conclude based on the emails from Dr. Shaul's office that his involvement in preparing the assessment report was minimal, superficial or cursory. The professional opinion of a duly qualified psychologist formed after a direct clinical encounter with a patient carries greater evidentiary weight than their mere approval of a report otherwise authored by a supervisee.

[35] Furthermore, the report of Dr. Shaul and Ms. Ilios has significant evidentiary shortcomings. It was prepared four years after the accident and the only medical records reviewed are a disability certificate from 2019 and the disputed treatment plan. The weight of the authors' conclusions as the causation of the applicant's symptoms is significantly eroded by the absence of objective medical records reviewed.

[36] The evidence the applicant has tendered does not provide a basis upon which to conclude that the Psychological Assessment he claims is reasonable and necessary as a result of the accident as required under s. 15 of the *Schedule*. Since the applicant has not met his onus, it is not necessary for me to engage in an analysis of the consequences of the applicant's non-compliance with the respondent's s. 33 request. The plan is simply not payable.

[37] As none of the medical benefits in dispute are reasonable and necessary as a result of the accident, no interest is owing.

Is the applicant entitled to the cost of the income replacement benefit report?

[38] Section 7(4) of the *Schedule* requires an insurer to pay the cost of an income replacement benefit accounting report prepared by an accredited professional if the expense is reasonable and necessary for calculating the insured person's entitlement to an income replacement benefit.

[39] The applicant submits he is entitled to the cost of an income replacement benefit accounting report. He submits the expense is reasonable because his entitlement arose after age 65, and the *Schedule* prescribes a different formula for calculating entitlement after age 65, one that is not straightforward and requires the professional skills of an accountant.

[40] The respondent submits that the expense is unnecessary because there has never been a dispute as to the quantum of the income replacement benefit at issue. The dispute has been over entitlement. It submits that the formula for calculating the quantum of benefits after age 65 is a straightforward one. The report initially failed to properly identify the period in dispute and had to be adjusted by the applicant's representative to reflect the correct dates. It submits that if the calculation of the quantum were as complex as the applicant claims, he would not have been able to prepare his own calculation amended for the period of entitlement after the May 24, 2017 disability certificate was submitted.

[41] I agree with the respondent. The cost of an income replacement benefits report is an unnecessary expense where there is no dispute over the quantum of the

claimed benefit. Further, the report does not correctly identify the time period in dispute, which undermines any finding of necessity and reasonableness. The report's contents demonstrate that the calculation of quantum in the applicant's circumstances is a straightforward matter, again undermining a finding of its necessity. An assessment of the report makes clear that the report was not reasonable and necessary. I conclude that the applicant is not entitled to the cost of the report.

CONCLUSION

[42] The applicant has not met his evidentiary onus in respect of any of the benefits claimed in this application. No interest is payable. The application is dismissed.

Released: June 14, 2021

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Theresa McGee
Vice-Chair