Tribunals Ontario
Licence Appeal Tribunal

Tribunaux décisionnels Ontario
Tribunal d'appel en matière de permis

Ontario

Citation: Sivalingam v. Unifund Assurance Company, 2021 ONLAT 19-014150/AABS

Released Date: 11/02/2021
File Number: 19-014150/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:

Nirloss Sivalingam

Applicant

and

Unifund Assurance Company

Respondent

DECISION AND ORDER

ADJUDICATOR: **Theresa McGee, Vice-Chair**

APPEARANCES:

For the Applicant: Lisa Thach, Paralegal

For the Respondent: Derek Greenside, Counsel

HEARD: **By way of written submissions**

REASONS FOR DECISION

BACKGROUND

[1] The applicant, Nirloss Sivalingam, was involved in an automobile accident on September 23, 2017, and sought benefits from the respondent, Unifund Assurance Company, pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010*[1] (the "*Schedule*").

[2] The respondent determined that the applicant's injuries fell within the Minor Injury Guideline and denied him medical benefits beyond the $3,500.00 funding limit available under the *Schedule* for the treatment of minor injuries. 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. Has the applicant sustained a minor injury as defined under the *Schedule* as a result of the accident, and is therefore subject to the $3,500 funding limit on treatment?

b. Is the applicant entitled to receive medical benefits recommended by Toronto Medical Centre as follows;

   i. The unapproved amount of $200.00 relating to a chiropractic treatment plan dated December 21, 2017; and

   ii. $1,656.81 for a physical therapy treatment plan dated January 10, 2018?

c. Is the applicant entitled to payments for the cost of examinations in the amount of $1,995.33 for a psychological assessment, recommended by Toronto Medical Centre in a treatment and assessment plan dated January 31, 2018?

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

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[1] O. Reg. 34/10.

RESULT

[4] The applicant sustained predominantly minor injuries in the accident.

[5] The applicant is entitled to $168.00 of the $1,656.81 treatment plan for physical therapy. This amount represents the expenses incurred under that plan from the 11th business day after the applicant submitted it to the day the respondent issued a valid denial of the plan. Interest is payable on this amount. The applicant has not proven the reasonableness or necessity of the expenses incurred under the plan after the denial date.

[6] The applicant has failed to establish entitlement to the unapproved $200.00 portion of the chiropractic treatment plan, because the Minor Injury Guideline applies to his impairments and the respondent's notice denying this amount was valid. He has also failed to establish entitlement to the psychological assessment, which the respondent validly denied.

ANALYSIS

[7] To be eligible for the medical benefits he seeks in this application, the applicant has the onus of proving, on a balance of probabilities, that his accident-related injuries are not predominantly "minor" as defined in the *Schedule*. The term "minor injury" is defined in s. 3(1) as "one or more of a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury."

[8] If the applicant's injuries are predominantly minor, the Minor Injury Guideline will apply. As s. 18(1) of the *Schedule* provides, funding for treatment under the Minor Injury Guideline is capped at $3,500.00. Where the Minor Injury Guideline applies and the funding limit has been exhausted, it is generally not necessary to examine whether individual treatment and assessment plans are reasonable and necessary as a result of the accident. However, in this case, the applicant claims that the respondent's denial notices were deficient under s. 38(8) of the *Schedule*, which requires that the notice be sent no more than 10 business days after the receipt of the treatment plan by the insurer.

[9] Non-compliance with s. 38(8) of the *Schedule* means the insurer cannot take the Minor Injury Guideline position with respect to the treatment plan. In addition, depending on whether expenses under the plan are incurred before a proper denial is issued, the insurer may be required to pay for those expenses under s. 38(11).

Did the applicant sustain minor, soft tissue injuries in the accident?

[10] The applicant's submissions on the Minor Injury Guideline issue focus largely on his allegation that the respondent did not comply with the notice requirements set out in s. 38(8) of the *Schedule*. While he does not expressly concede that his impairments are minor, he does not argue that his injuries exceed the definition of a minor injury. He refers me to the hospital records from the date of the accident that show a final diagnosis of "soft tissue injury", and to two disability certificates that list his accident-related injuries as sleep disorders, nervousness, and reaction to severe stress, all of which fall within the minor injury definition set out in s. 3(1).

[11] While the applicant submits that he "reported psychological impairments resulting from the accident" to practitioners at Toronto Medical Centre, and that he "suffered from impairments that can be seen as barriers in his recovery preventing him from returning to his activities of normal living and pre-accident level of psychological functioning", he does not directly submit or advance evidence that he ever received a diagnosis of a psychological impairment. In fact, he directs me to the Section 44 Psychological Evaluation of Dr. John Lee, who opined that the applicant suffers from accident-related "mild adjustment symptoms" falling short of a mental health diagnosis.

[12] Based on the evidence, I find that the applicant suffered minor, soft tissue injuries in the accident. I find that, on a balance of probabilities, his reported psychological concerns constitute the clinically associated sequelae of the applicant's minor injuries, and therefore fall within the definition of a minor injury. There is no basis for removal from the Minor Injury Guideline in the applicant's post-accident condition.

Did the respondent's denials comply with the timeline in s. 38(8) of the *Schedule*?

[13] The applicant submits that the respondent failed to comply with s. 38(8) of the *Schedule*, and therefore is prohibited from taking the position that the Minor Injury Guideline applies to his impairments.

1) The chiropractic services treatment plan

[14] The applicant submits that the respondent's denial of $200.00 for the completion of the December 21, 2017 treatment plan was not clear and sufficient for him to understand which treatments or services the respondent was agreeing to pay. He submits the notice did not identify the gait analysis the respondent was refusing to fund.

[15] Given that notice complying with s. 38(8) has never been issued, the applicant submits, and he has incurred the services under the plan, the respondent is required under s. 38(11) to pay the outstanding $200.00.

[16] The respondent submits that its denial of $200.00 complied with the requirement under s. 38 to provide the "medical and any other reasons" for the denial. It submits that it sent correspondence with an addendum setting out a detailed breakdown of the items in the treatment plan it agreed to pay. With respect to the unapproved $200.00, the addendum stated, under the line item "ocf18 doc/assess":

> "Treatment approved as per modifications. The maximum FSCO approved rate for OCF-18 assessment and documentation is $200.00. We partially approved $200.00 of the $400.00 proposal."

[17] The parties' positions on whether the denial notice was clear and straightforward pivot on how the disputed service was identified in the treatment plan (OCF-18). There are **two** OCF-18s for the same proposed intervention in evidence, one dated December 13, 2017, the other dated December 14, 2017. The former lists the item in dispute as a "test, total body" while the latter calls it a "gait analysis". The applicant's position is that the December 13, 2017 OCF-18 is the relevant document and that the denial notice is deficient for failing to specifically identify "gait analysis" in the denial notice. The respondent submits that the OCF-18 it possessed when preparing the denial notice is the one dated December 14, 2017, and that its denial notice clearly identified the disputed "test, total body" as an "assessment".

[18] I have carefully reviewed the records in evidence. I need not make finding as to which of the OCF-18s was in possession of the respondent at the time it issued the December 21, 2017 denial notice. The sufficiency of the notice does not turn on whether the OCF-18 describes the disputed item as a "gait analysis" or a "test, total body". The denial addendum communicates clearly, straightforwardly, and in detail that the reason for non-payment of the item was that it exceeded the limit for OCF-18 assessment and documentation.

[19] Even accepting the December 13, 2018 OCF-18 as the relevant OCF-18, as the applicant asks me to do, I find that the denial properly addresses the disputed item. The December 13, 2018 OCF-18 details the proposed expenses in its "Additional Comments" section. The details provided there make it clear that the gait analysis is not chiropractic treatment; therapy – multiple reasons; or physical rehabilitation sessions. Since there are no other categories of goods or services outlined in the plan, the $ "gait analysis" clearly falls within the $200.00 limit is set

out in the Professional Services Guideline for "examinations, assessments and expenses related to professional services (as referred to below) that are involved in such examinations and assessments, and all other activities, tasks and expenses involved in the completion and submission of forms".[2]

[20] Whether described in the OCF-18 as a "gait analysis" or a "test, total body" does not detract from the clarity of the denial notice, which directly addressed the item as an "assess[ment]" falling under the $200.00 cap. The Professional Services Guideline, which is publicly available and which parties are expected to know, is clear that an insurer is not liable for more than $200.00 for the assessments and documentation involved in preparing an OCF-18. The "medical and any other reasons" for the denial of the expense were clearly set out in straightforward language capable of being understood by a sophisticated person, per the Supreme Court of Canada's ruling in *Smith v. Co-operators General Insurance Co.*[3] I find that the notice satisfies the requirements under s. 38(8).

2) The physical therapy treatment plan

[21] The applicant submits that the respondent did not properly deny the January 10, 2018 treatment plan for chiropractic treatment until May 15, 2018, when it sent an explanation of benefits accompanying a s. 44 insurer's examination. By this time, the applicant submits, the treatment was fully incurred.

[22] The Tribunal has consistently held that an explanation of benefits denying a benefit and requesting an insurer's examination will satisfy s. 38(8), provided that all other notice requirements are met. It would be an absurd requirement to expect insurers to arrange s. 44 examinations, obtain their results, and adjust a claim accordingly within 10 business days. This is especially so considering that s. 44(6) of the *Schedule* requires insurers to provide five business days of notice for in-person examinations. A denial accompanied by a request for an insurer's examination is a valid denial, as long as it satisfies all other requirements set out in s. 38(8).

[23] Although I reject the applicant's submission that the respondent's February 9, 2018 explanation of benefits was invalid because it was not a final denial, there remains another difficulty with the timing of the notice. The OCF-18 tendered by the respondent shows a submission date through the Health Claims for Auto Insurance (HCAI) system of January 11, 2018. The adjuster completed the OCF-18 refusing to approve the plan on January 24, 2018. But the denial notice was

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[2] Superintendent's Guideline No 01/11.
[3] 2002 SCC 30.

not communicated to the applicant until February 9, 2018 - 21 business days post-submission. The respondent has not tendered any evidence to show that it corresponded with the applicant about this treatment plan before this date.

[24] Section 38(11) of the *Schedule* provides that a denial notice issued more than 10 business days after receipt of a treatment plan subjects the insurer to two consequences. First, it is prohibited from taking the Minor Injury Guideline position in respect of the treatment plan. Second, it is liable to cover the cost of any goods, services, assessments, or examinations incurred between the 11th business day after the plan was submitted and the date on which the insurer issues a proper denial notice. I will refer to this period as the "shall pay" period.

[25] Here, the "shall pay" period began on January 26, 2018 (11 business days after the applicant submitted the treatment plan) and ended on November 9, 2018 (the date of the denial). The applicant has tendered an invoice (OCF-21) dated May 28, 2018, establishing that the following expenses were incurred during the "shall pay" period:

a. $58.00 physical rehabilitation session (January 31, 2018);

b. $65.00 chiropractic treatment (January 31, 2018); and

c. $45.00 therapy, multiple sites (January 31, 2018).

[26] The remainder of the treatment plan was incurred after the denial date.

[27] I find that the respondent is liable to pay $168.00 as a penalty for issuing its denial notice outside the timeline required under s. 38(8).

[28] I now return to the first consequence of non-compliance with s. 38(8), the insurer is prohibited from taking the Minor Injury Guideline position in respect of the applicant's impairments: the respondent may not rely on the fact that the applicant sustained minor injuries in the accident in refusing to fund the physical therapy claimed in the disputed plan. However, as I have highlighted, most of the services under this plan were incurred **after** the "shall pay" period ended. Because the Minor Injury Guideline does not apply to the plan, the analysis must move to the standard test for entitlement to medical benefits for the expenses incurred outside the "shall pay" period. That test is set out in s. 15 of the *Schedule*. Under s. 15, the applicant bears the onus of proving that the benefit is "reasonable and necessary" as a result of the accident.

[29] I pause here to address two points of law. First, contrary to the applicant's submissions, the prohibition in s. 38(11) on an insurer taking the Minor Injury

Guideline position applies to the treatment plan affected by the late denial, not the entire Tribunal application. This was established by the Divisional Court in *Zheng, Cai v. Aviva Insurance Company of Canada*.[4] Consequently, the respondent's late denial only bars it from taking the Minor Injury Guideline position in respect of the physical therapy plan.

[30] Second, the respondent's submission that the applicant must prove the reasonableness and necessity of **all** of the expenses incurred under the plan regardless of whether they fall within or outside of the "shall pay" period is incorrect. The respondent's reliance on the Tribunal's decision in *Zeitun v. Royal Sun Alliance*[5] is misplaced. That decision dealt with benefits the insurer was not legally obligated to fund because they were incurred before the treatment plan was submitted. That is not the case here. The Divisional Court recently held in *Kyrylenko v. Aviva Insurance Canada* [*Kyrylenko*] that there is **no** requirement to engage in a "reasonable and necessary" analysis when dealing with expenses incurred under a treatment plan during a "shall pay" period.[6] As such, the applicant's onus of proof only extends to those expenses incurred **after** the "shall pay" period, when the respondent's obligation to fund the disputed benefits was no longer automatic. The two rules in s. 38(11) interact such that:

a. the Minor Injury Guideline does not apply to the plan; and

b. the applicant retains the onus of proving entitlement to expenses incurred outside the "shall pay" period.

[31] Failing to conduct a "reasonable and necessary" analysis for the expenses incurred after a valid denial would lead to an absurd result: it would relieve the applicant of their onus to prove entitlement to a benefit long after the insurer's penalty period had ended. In effect, it would nullify the language in the provision that imposes an end date "on the day the insurer gives a notice described in subsection (8)". While s. 38(11) is clear as to the insurer's liability to pay for services incurred **within** the "shall pay" period – and there, an analysis of whether the applicant has underlying entitlement to the benefit is unnecessary - for expenses incurred **outside** that period, (including most of the expenses in dispute in this matter), the Minor Injury Guideline does not apply, and a s. 15 reasonable and necessary analysis is called for.

[32] I find, on review of the evidence, that the physical therapy proposed in the treatment plan falls short of the test in s. 15 for reasonable and necessary

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[4] 2018 ONSC 5707.
[5] 2020 ONLAT 19-011900/AABS.
[6] *Kyrylenko* at para. 13.

expenses. The medical evidence from the months following the accident does not support a need for facility-based treatment at the time this plan was proposed. The applicant sustained minor, soft tissue injuries in the accident. The respondent's examiner, Dr. Ato Sekyl-Otu, an orthopedic surgeon, opined that the applicant suffered uncomplicated myofascial strains in the accident. This was after a review of the medical evidence and a physical examination of the applicant. Objectively, Dr. Sekyl-Out observed, any signs of pathology in the applicant had resolved. He observed excellent range of motion. Dr. Sekyl-Otu opined that the applicant was demonstrating self-limiting behaviours; there were marked discrepancies between his self-reported pain and objective signs of pathology. The rhythm and motion of his cervical spine varied markedly between formal testing and informal testing using distraction techniques. Taken together, the absence of medical evidence to support the need for ongoing physical therapy and the findings of Dr. Sekyl-Out satisfy me that the treatment plan is neither reasonable nor necessary in relation to the applicant's accident-related injuries.

3) The psychological assessment

[33] The applicant submits that the treatment plan proposing the psychological assessment, dated January 31, 2018, was submitted to the respondent on March 5, 2018 and denied March 17, 2018. The applicant makes no submission that the denial of this treatment plan failed to comply with s. 38(8). He submits, without directing me to any provision of the *Schedule*, that the respondent should nonetheless be ordered to pay the cost of the proposed assessment. I see no legal basis for granting such an order. Again, the consequences for failing to issue a proper, timely denial apply to the affected treatment plan, not the entire application. This treatment plan was properly denied and is not payable because the Minor Injury Guideline has been exhausted.

CONCLUSION AND ORDER

[34] The injuries the applicant sustained in the accident were predominantly minor injuries as defined in s. 3 of the *Schedule*. The Minor Injury Guideline therefore applies. The applicant is entitled to $168.00 of the $1,656.81 treatment plan for physical therapy. This amount covers the expenses incurred under that plan during the period beginning on the 11th business day after submission of the plan and the date the respondent issued a valid denial of the plan. The applicant has not failed to establish entitlement to the remaining benefits in dispute.

Released: November 2, 2021

Theresa McGee

Theresa McGee
Vice-Chair