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

Ontario

Citation: S.V. vs. Aviva Insurance Canada, 2020 ONLAT 18-011347/AABS

Released Date: 06/01/2020
File Number: 18-011347/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:

[S.V.]

Applicant

and

Aviva Insurance Canada

Respondent

DECISION AND ORDER

VICE-CHAIR: **D. Gregory Flude**

APPEARANCES:

For the Applicant: David Levy, Counsel

For the Respondent: Geoffrey Keating, Counsel

Heard by way of written submissions

REASONS FOR DECISION AND ORDER

OVERVIEW

[1] The applicant, [S.V.], was involved in an automobile accident on **October 3, 2015** and sought benefits pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010, O. Reg 34/10* (the "*Schedule*"). He applied to the respondent, Aviva Insurance Canada ("Aviva"), for a non-earner benefit and for a medical benefit. When Aviva denied the claimed benefits he applied to this Tribunal for dispute resolution.

[2] [S.V.] raises two main submissions in support of his entitlement to the non-earner benefit. The first submission concerns an alleged failure of Aviva to deny his claim for the benefit in the proper form until December 18, 2018. In his submission, the *Schedule* mandates that Aviva must now pay him the non-earner benefit up to the date it complied with the requirements of the *Schedule*.

[3] The second submission addresses [S.V.]'s entitlement to the non-earner benefit, independently of the alleged technical failures of Aviva to comply with the *Schedule*. [S.V.] argues entitlement to the benefit because he meets the test for entitlement under the *Schedule*. He submits that the accident has caused him to have a complete inability to live a normal life.

[4] With respect to the medical benefit, [S.V.] submits that it is reasonable and necessary to treat the impairments he sustained as a result of the accident.

[5] Aviva submits that [S.V.] has admitted that it properly denied the non-earner benefit on November 26, 2016 and the medical benefit on January 9, 2017 in his Notice of Application for Dispute Resolution. It also submits that, if its November 26, 2016 denial was defective, it was incumbent on [S.V.] to bring that deficiency to its notice soon after receipt of the denial letter. Aviva submits that by not raising the issue contemporaneously with the denial but waiting until he filed his hearing submissions, [S.V.] has fatally impaired his ability to raise it now. It argues that it is now prejudiced by [S.V.]'s failure to bring the deficiency to its notice.

ISSUES

[6] The issues in dispute were identified and agreed to as follows:

i. Is the applicant entitled to a non-earner benefit in the amount of $185.00 per week from April 3, 2016 to date and ongoing?

ii. Is the applicant entitled to a medical benefit in the amount of $2,894.70 for physiotherapy, chiropractic treatment and massage recommended by Gibson Wellness Centre in a treatment plan ("OCF-18") submitted on December 29, 2016, and denied on January 9, 2017?

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

iv. Is the applicant entitled to an award under *Ontario Regulation 664* because the respondent unreasonably withheld or delayed the payment of benefits?

RESULT

[7] I find that the November 26, 2016 letter is a valid denial. It clearly states that the benefit is being denied and cites the medical reasons, that is, it refers [S.V.] to the findings of Aviva's assessors. That is not the end of the enquiry, however. I find that there was no proper denial of benefits prior to November 26, 2016. [S.V.] is entitled to a non-earner benefit for the period commencing on April 3, 2016, the end of the 26-week deductible period, to November 26, 2016.

[8] From November 26, 2016 onwards, [S.V.] has the onus of establishing entitlement to a non-earner benefit. There is no evidence before me establishing that [S.V.] suffers a complete inability to live a normal life. The evidence suggests that [S.V.] is not incapable of performing substantially all of the activities he performed before the accident. Similarly, I find that the treatment he seeks is not reasonable and necessary.

ANALYSIS

[9] I will discuss three areas concerning [S.V.]'s entitlement to a non-earner benefit: the period prior to November 26, 2016, the effect of the November 26, 2016 letter and the statutory test for entitlement. Finally, I will address the claim for a medical benefit and my finding that the medical benefit sought is not reasonable and necessary.

Improper denial

[10] There are two periods in issue with respect to the improper denial: the period from October 3, 2015 to November 26, 2016, and the period after November 26, 2016. I will address the period up until November 26, 2016 first. During that period, Aviva failed to comply with provision of the *Schedule* regarding notice and providing medical and other reasons for the denial.

[11] [S.V.] relies on two sections of the *Schedule*, s. 36(4)(b) and s. 44(5). He argues that Aviva failed to comply with its obligation as set out in these two sections. Section 36(4)(b) states:

> (4) Within 10 business days after the insurer receives the application and completed disability certificate, the insurer shall,
>
> > (b) give the applicant a notice explaining **the medical and any other reasons** why the insurer does not believe the applicant is entitled to the specified benefit and, **if the insurer requires an examination under section 44** relating to the specified benefit, **advising the applicant of the requirement for an examination**. [emphasis added]

[12] Section 36 (6) provides that Aviva is liable to pay for the non-earner benefit until such time as it complies with s. 36(4).

[13] [S.V.] served his Application for Accident Benefits ("OCF-1") on October 7, 2015. He followed this with a Disability Certificate ("OCF-3") on November 2, 2015. On receipt of the OCF-1, Aviva noted that [S.V.] was not employed and had not been employed for 26 out of the preceding 52 weeks. It sent him a letter dated October 19, 2015 outlining the benefits he might qualify for. In addressing entitlement to a non-earner benefit, the letter correctly pointed out that that there was a 26-week deductible.

[14] Once [S.V.] forwarded the OCF-3 on November 2, 2015, he had completed the formal requirements to apply for a non-earner benefit. The OCF-3 identifies October 3, 2015 as the date when [S.V.] became unable to carry on a normal life. It then fell to Aviva to fulfil its obligations under s. 36(4)(b).

[15] Aviva did not respond to receipt of the OCF-3 until June 2, 2016, seven months after receipt. On that date, Aviva sent a letter giving [S.V.] notice that it wished to have him examined by its assessors. Section 36(4)(b) required that notice to set out medical and other reasons for the position it was taking. On July 5, 2016, Aviva sent a notice that it had arranged medical examinations of [S.V.].

[16] [S.V.] submits, and I agree, that the June 2, 2016 letter fails to set out medical reasons why Aviva wishes to deny him a non-earner benefit. The letter simply states that Aviva wants to determine [S.V.]'s initial entitlement to the benefit. It does not delineate why Aviva does not believe [S.V.] is entitled to the specified benefit, as required by s. 36(4)(b).

[17] To be compliant, s. 36(4) demands that Aviva give medical and all other reasons. The reasons given, to determine entitlement, may satisfy the requirement for all other reasons, but it does not set out grounds on which Aviva bases its belief that [S.V.] is not medically entitled to the benefit. What might satisfy the requirement for medical reasons has been reviewed by the Tribunal in earlier cases.

[18] In *M.B. v. Aviva Insurance Canada*, 2017 CanLII 87160 (ON LAT) ("*M.B.*"), the Executive Chair set out the requirements for medical reasons. She recognizes that insurance adjusters are not medical professionals, nor is she of the opinion that insurance companies should retain in-house medical staff to opine on applications. She does, however, set out a minimum consideration. At paragraph 26 she states:

> In my view, an insurer satisfies its obligation to provide its "medical and any other reasons," whether under s. 44(5)(a) or elsewhere, by explaining its decision with reference to the insured's medical condition and any other applicable rationale. That explanation will turn on the unique facts at hand. Therefore, it would be unwise to attempt to outline a comprehensive approach to doing so. Nevertheless, an insurer's "medical and any other reasons" should, at the very least, include specific details about the insured's condition forming the basis for the insurer's decision or, alternatively, identify information about the insured's condition that the insurer does not have but requires. Additionally, an insurer should also refer to the specific benefit or determination at issue, along with any section of the *Schedule* upon which it relies. Ultimately, an insurer's "medical and any other reasons" should be clear and sufficient enough to allow an unsophisticated person to make an informed decision to either accept or dispute the decision at issue. Only then will the explanation serve the *Schedule*'s consumer protection goal.

[19] The June 2, 2016 letter advising [S.V.] that Aviva wished to have him assessed by healthcare practitioners of its choosing makes no reference to medical documentation on file, [S.V.]'s medical condition, or medical documents Aviva needs but does not have. In this it falls short.

The November 26, 2016 Denial Letter

[20] As I find below, Aviva did not provide [S.V.] with a valid denial letter until November 26, 2016. As a result, in accordance with s. 36(6), I find [S.V.] is entitled to a non-earner benefit for the period of April 3, 2016 to November 26, 2016.

[21] I do not accept [S.V.]'s interpretation of the interplay between s. 36(4)(b) and s. 44(5). [S.V.] submits that s. 36(4)(b) references notices of examination under s. 44(5). In his submission, both the June 2, 2016 letter issued pursuant to s. 36(4)(b) and the notices of examination issued under s. 44(5) must comply with the requirement to give medical and other reasons for the June 2, 2016 denial to be valid.

[22] Both s. 36(4)(b) and s. 44(5) oblige Aviva to set out medical and other reasons for the decision it has made to deny a non-earner benefit in the case of the former, and to require attendance at medical assessments in the case of the latter. I have found above that the June 2, 2016 letter does not identify medical reasons for denying [S.V.] a non-earner benefit. In essence, he submits that even if the June 2, 2016 letter did set out adequate medical reasons, the fact that the s. 44(5) notices were defective would render the June 2, 2016 letter invalid. In my view, he misreads s. 36(4)(b).

[23] Aviva's obligation under s. 36(4)(b) was to advise [S.V.] that it was denying his claim for a non-earner benefit, set out the medical and other reasons for the denial and advise him that it required him to attend assessments. It requires no more than it identify the section under which it will schedule the assessments at some future date. I see nothing in the section that incorporates the contents of the s. 44(5) notices. Defective s. 44(5) notices trigger their own set of remedies as will be discussed below.

[24] The lack of linkage between s. 36(4)(b) and s. 44(5) caused [S.V.] no prejudice. He had a remedy. [S.V.]'s remedy, when faced with what I agree were defective notices of examination was to refuse to attend until the notices were compliant. Any delay arising out of an insistence on his rights to be served with compliant notices for the medical examinations would simply extend the period until Aviva could issue an appropriate and compliant notice denying the benefit. During this period, [S.V.] would continue to be entitled to payment of the non-earner benefit. He chose not to exercise his remedy. He attended the requested examinations.

[25] Nor does the discussion about waiving rights set out in *M.B.* avail [S.V.]. *M.B.* and related decisions finding medical reasons deficient clarify an important policy requirement for giving medical reasons. They enable applicants for benefits to make informed decisions about whether to attend an insurer's examination or waive their claim because they do not want the intrusion into their personal space that a medical examination involves. Having attended the examinations, that policy consideration has no further role to play. [S.V.] made the decision to attend and suffered the invasion of his personal space. Nothing is now served by

retroactively holding that he did not have to go in the first place. That issue is moot.

[26] There now remains the question of whether to November 26, 2016 letter is compliant with s. 36(4)(b). I find that the letter does comply with the requirements of s. 36(4)(b). It cites the denial of the benefit, including the non-earner benefit and states that the denial is based on the attached medical reports determining that [S.V.] does not meet the test for a non-earner benefit and needs no further treatment. It now remains to determine if [S.V.] does, in fact, meet the test for a non-earner benefit.

Failure to Meet the Test for a Non-Earner Benefit

[27] The test for a non-earner benefit is set out in s. 12 of the *Schedule*, as follows:

> **12.** (1) The insurer shall pay a non-earner benefit to an insured person who sustains an impairment as a result of an accident if the insured person satisfies any of the following conditions:
>
> 1. The insured person suffers a complete inability to carry on a normal life as a result of and within 104 weeks after the accident and does not qualify for an income replacement benefit.

[28] The term “complete inability” is further defined in the s.3(7) of the *Schedule*, as follows:

> (7) For the purposes of this Regulation,
>
> (a) a person suffers a complete inability to carry on a normal life as a result of an accident if, as a result of the accident, the person sustains an impairment that continuously prevents the person from engaging in substantially all of the activities in which the person ordinarily engaged before the accident;

[29] The onus is on [S.V.] to establish on a balance of probabilities that, as a result of the accident, he is continuously prevented from engaging in substantially all of the activities in which he ordinarily engaged before the accident. He has advanced no reliable evidence to show an inability to engage in his normal activities.

[30] The Ontario Court of Appeal has provided a framework for evaluating claims for a non-earner benefit in *Heath v. Economical Mutual Insurance Company*, 2009 ONCA 391 (CanLII) (“*Heath*”). Central to the *Heath* analysis is a comparison of

the lifestyle enjoyed by an applicant before the motor vehicle accident with the applicant's lifestyle after the accident. The test is subjective addressing the pre- and post-accident circumstances of the individual applicant. It is also qualitative. While pain, *simpliciter*, is not a ground for qualification, if an applicant can perform a pre-accident activity but is effectively precluded from enjoying it because of pain, then that will be taken into consideration.

[31] Applying *Heath* to the current facts, the most glaring omission is the lack of first-hand evidence from [S.V.] about his life before and after the accident. There is no affidavit from him even though the case conference order setting up the hearing does not limit him in any way from submitting affidavit evidence. Thus, while his submissions are full of statements about his life before the accident and activities he cannot now do, many of these assertions are not supported by evidence. What evidence there is in support of his entitlement comes from statements made to his family doctor and medical assessors, both assessors retained by him and those retained by Aviva. At best this evidence is equivocal.

[32] Aviva raises the lack of evidence in its written submissions, as follows:

> At several points in his written submissions, the Applicant makes claims which simply have no evidentiary basis. For example, no evidence has been led to substantiate the allegations that the Applicant was actively searching for work pre-accident, that he was providing care for his daughter, that he was active socially, or that he volunteered at his temple. The totality of the allegations contained in paragraphs 27 to 29 of the Applicant's submissions simply have no evidentiary basis.

[33] [S.V.] has been assessed by three specialists on behalf of Aviva. He was assessed psychologically by Dr. Konstantin Zakzanis; neurologically by Dr. Dubravka Dodig; and physically by Dr. Gregory Soon-Shiong. In his report, Dr. Zakzanis notes that the applicant told him:

> As for his social and recreational activities, [S.V.] noted that he no longer attends weddings or goes to temple as often as he did pre-accident, given that he is "not in good mood'. He has also reportedly reduced going on "outings with friends" (e.g., to their houses or birthday parties) and visiting his family members given his social withdrawal. He stated that he only "rarely' watches movies, watches foreign news, or reads the newspaper given his loss of interest to these ends. He denied having travelled post-accident.

[34] In terms of his work search, [S.V.] reported to his assessing psychologist, Dr. P. H. Waxer, that: “He was looking for suitable employment when his accident occurred [sic].” In describing his pre-accident leisure interests to Dr. Waxer, [S.V.] stated:

> When asked about his leisure interests, prior to his MVA, [S.V.] stated that he obtained most of his exercise by walking. [S.V.] indicated that his social life primarily consisted of visiting with nearby relatives, attending house parties or inviting friends and families to events such as his daughter’s birthday. [S.V.] actively visited his Hindu Koele [sic], volunteering to clean in his temple. [S.V.] indicated that he had limited opportunity to travel but relayed that he had visited two of his brothers, currently residing in Switzerland. [S.V.] indicated that he had also enjoyed a road trip to [a town in Ontario] with his wife. When active around his home, [S.V.] helped his daughter with her homework and played table games together. When it was time for passive relaxation, [S.V.] watched Tamil cable television, listened to Carnatic vocal and instrumental music and read his Tamil newspaper.
>
> When asked to generate a percentage estimates of his pre-accident life interests that he is presently able to enjoy, [S.V.] generated an estimate of approximately 50%, “with pain”.

[35] A review of the medical reports set out above indicates that there is evidence that, pre-accident, [S.V.] was looking for suitable employment, although the word “actively” may be an embellishment; he was socializing with friends, he did care for his daughter, although the suggestion that he was the primary caregiver is called into question both by his own description of his role and his frequent exclusion from the family residence because of his “crazy wife;” and that he did volunteer at his place of worship.

[36] The fact that [S.V.] rates his own post-accident abilities at 50% is telling. The test to qualify for a non-earner benefit is a complete inability to live a normal life. This test is further refined to an impairment that prevents [S.V.] from continuously engaging in substantially all of the activities he previously engaged in. The evidence indicates that [S.V.] was not continuously prevented from substantially engaging. Indeed, on a review of Dr. Waxer’s report, the facts as he finds them are not consistent with that doctor’s finding that [S.V.] meets the test for a non-earner benefit. Both Dr. Zakzanis and Dr. Waxer record that [S.V.] continued to engage in most of his pre-accident activities, albeit at a reduced level, even as low as 50%.

[37] I find that [S.V.] does not meet the test for entitlement to a non-earner benefit.

OCF-18 in the amount of $2,894.70 for physiotherapy, chiropractic treatment and massage recommended by Gibson Wellness Centre submitted on December 29, 2016

[38] Gibson Wellness Clinic has recommended physiotherapy, chiropractic and massage treatment in the amount of $2,894.70. Aviva submits that this treatment is not reasonable and necessary on two grounds: the condition complained of does not arise from injuries sustained in the accident, and the treatment is unlikely to be effective. The medical record indicates that [S.V.] has complained of back pain impacting his left leg since 2012. In 2012, he identified the problem as arising in 2011. A pre-accident MRI showed that his back pain and problems arise from degenerative changes in his spine including disc bulges and foraminal impingement. He has had physiotherapy and massage treatment for this condition since at least 2012 and it has proved ineffective. He now attributes his pain to the accident and seeks treatment under the *Schedule*.

[39] Here is a brief review of [S.V.]'s medical records:

Pre-Accident Reports

i. November 14, 2012 - complaint of bilateral lower back pain radiating down left leg starting about a year before the visit. He had tried massage but not physiotherapy.

ii. March 12, 2013 – complaint of lower back pain at night radiating down left leg. Physiotherapy ineffective. The back problem is tied to a 2004 workplace back injury. Unable to work because of pain.

iii. July 15, 2013 MRI - shows scoliosis with degenerative changes and moderate L4-L5 foraminal stenosis.

iv. March 6, 2014 – complaint of lower back pain. Record notes a long history of back pain. It further notes that physiotherapy is ineffective. Source of problem identified moderate neural foraminal stenosis and L5-S1 disc protrusion touching the S1 nerve root.

v. August 13, 2015 – complaint of back pain and seeking massage.

vi. September 24, 2015 – follow-up regarding back pain. Recommendation of no heavy lifting or bending.

Post- Accident Reports

vii. October 8, 2015 – report of back pain starting on October 4, 2015, the day after the accident.

viii. August 18, 2017 – complaint of muscle pain for the previous 3 to 4 months. Spinal exam and range of motion normal. Report of 150 min/week of moderate to intense walking with no concerns when active.

ix. February 27, 2019 – some left-sided neck and shoulder pains. No treatment seems to have been sought or recommended for this condition.

[40] The above record review suggests that [S.V.]'s back issues pre-date the October 3, 2015 by some years and may date back to a workplace injury in 2004 that ultimately led to him being laid-off in 2006 from his job as a cabinet maker. The post accident record indicates that there may have been occasional flare-ups of his back pain, but his family doctor does not recommend treatment.

[41] I am satisfied on the medical record that [S.V.] did not incur any impairments of function as a result of the accident. He reported being physically incapable of working pre-accident and was recommended not to engage in heavy lifting. He reports no new impairment of function to his family doctor in the infrequent visits dealing with back pain following the accident. If anything, he visited his family doctor less frequently for back issues following the accident than before it. In numerous other visits to his family doctor post-accident the doctor's concern is developing diabetes and, latterly, cataracts.

[42] Looking at the goals of the OCF-18 itself, it is not persuasive that the proposed treatment is reasonable and necessary. The OCF-18 sets out the goals of the proposed treatment as pain reduction, increase in strength, and increase in range of motion. The further goals are identified as return to activities of normal living and return to pre-accident work activities. It is hard to support the treatment modalities and goals of this OCF-18 in light of the medical record.

[43] The proposed treatment consists of exercise, heat, acupuncture and exercise. I am not satisfied that these approaches are likely to be any more successful than the physiotherapy and massage [S.V.] received before the accident. In his orthopaedic medical assessment of [S.V.], Dr. Soon-Shiong notes that:

> As far as his treatment is concerned, [S.V.] has had an extensive program of physical therapy and rehabilitation [since the accident], well beyond what would have been expected for the type of minor soft tissue injuries sustained. He does not require any further

> facility-based treatment beyond that which has been received and can continue with his exercises on a self-directed basis at home.

[44] Dr. Soon-Shiong's opinion is based on incorrect medical history information provided by [S.V.]. In particular, Dr. Soon-Shiong notes:

> Past medical history is positive for asthma. [S.V.] has been otherwise healthy. He has no previous history of any musculoskeletal ailments and he has not been involved in any previous motor vehicle accidents causing injuries.

[45] As stated above, [S.V.] has a long history of back pain. Despite the incorrect information, Dr. Shoon-Siong concludes that the OCF-18 is not reasonable and necessary. I agree with him.

AWARD UNDER O. REG 664

[46] Section 10 of *O. Reg 664* provides that I may make an award of up to 50% of any outstanding amount if I finds that an insurer has unreasonably delayed or withheld the payment of a benefit. In addition, if I were to make such an award then interest is charged on the outstanding amount at the rate of 2% per month, compounded monthly.

[47] The delay in processing the claim in this case is two months, the period between the end of the 26-week deductible and June 2, 2016 when Aviva sent its notice, albeit defective, advising [S.V.] that it wanted him to attend insurer's examinations. Thereafter the file was processed with reasonable expedition.

[48] In the overall scheme of things, I do not find Aviva unreasonably delayed or withheld payment. At first glance, the November 2, 2015 OCF-3 did not support [S.V.]'s claim for a non-earner benefit. It stated that his period of total inability would last for 9 to 12 weeks, a period that ended well before the 26-week deductible period expired. I have been pointed to no correspondence between [S.V.] and Aviva that would put Aviva in notice that the period of alleged disability was longer than 9 to 12 weeks, thereby injecting some sense of urgency into the proceeding.

CONCLUSION AND ORDER

[49] Based on the above analysis, I find that Aviva did not comply with its obligations under s. 36(4)(b) of the *Schedule* to issue a compliant denial letter until November 26, 2016. Pursuant to s. 36(6), I order Aviva to pay [S.V.] a non-earner benefit for the period from April 3, 2016 to November 26, 2016.

[50] Pursuant to s. 51(3) and (4) of the *Schedule*, interest is payable at the rate of 1% per month, compounded monthly, for the period commencing when the amount became due until the date the Notice of Application for Dispute Resolution was filed and thereafter at the rate set out in the *Courts of Justice Act* R.S.O. 1990 c. C.43 until the date of the release of my decision. I see no discretion in the *Schedule* that permits me to vary the interest rate.

[51] The balance of the claim for a non-earner benefit is dismissed.

[52] I find that the OCF-18 dated December 29, 2016 is not reasonable and necessary.

[53] I find that this is not an appropriate case for an award under s. 10 of *O. Reg 664*.

Released: June 1, 2020

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D. Gregory Flude
Vice-Chair