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

2018 CanLII 140993 (ON LAT)

Tribunal File Number: 17-005125/AABS

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

Between:

Z.S.

Applicant

and

Aviva Insurance Canada

Respondent

DECISION

ADJUDICATOR: Anita Goela

APPEARANCES:

Counsel for the Applicant: Alicia D. Stuart

Counsel for the Respondent: Geoffrey L. Keating

Written Hearing: March 1, 2018

BACKGROUND

[1] The applicant was involved in an automobile accident on July 3, 2015 and sought benefits pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2011*[1] (the "*Schedule*").

[2] The respondent initially denied the applicant's claim for a medical benefit because it determined that the applicant's injuries fit the definition of "minor injury" prescribed by s.3 (1) of the *Schedule*, and therefore, fall within the Minor Injury Guideline ("the MIG"). The applicant was later removed from the MIG based on the findings of an insurer's examination.

[3] The respondent now submits that the medical benefit claimed by the applicant is not reasonable and necessary, under s.15 (1) of the *Schedule*.

ISSUES IN DISPUTE

[4] The case conference report dated November 10, 2017 lists eight issues in dispute. The Tribunal received correspondence from the applicant on January 30, 2018 that only two issues remain to be determined, as follows:

i. Is the applicant entitled to receive a medical benefit in the amount of $2,000.00 for occupational therapy that was recommended by Ashley Kuchar in a treatment plan dated August 17, 2015 and denied on August 31, 2015?

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

RESULT

[5] The applicant is entitled to the medical benefit in the amount of $2,000.00. Because I find that the benefit is payable, interest is also owing.

ANALYSIS

Proper denial pursuant to section 38(8)

[6] Section 38(8) of the *Schedule* provides that the insurer shall give the insured person notice when it denies benefits that provide the medical reasons and other reasons why the insurer considers the benefits not to be reasonable and necessary. Section 38(11) provides that if the insurer fails to give proper notice, the insurer is liable to pay for the disputed benefits.

[7] The applicant submits that the respondent did not provide a proper denial as required in s. 38 of the *Schedule* and therefore, the assessment should be funded pursuant to s. 38(11). I find that the respondent's notice was deficient because:

i. It misstated the opinion of Dr. Khaled, a general practitioner who conducted an insurance examination on the applicant and drafted a report

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[1] O. Reg. 34/10.

dated June 17, 2016. The respondent relied on the opinion of Dr. Khaled to deny the treatment plan. In the denial letter, the respondent stated that Dr. Khaled did not find the treatment plan reasonable and necessary. However, Dr. Khaled stated that the applicant's injuries are treatable within the MIG; and

ii. The respondent failed to re-assess the treatment plan after the applicant was removed from the MIG.

Denial letters

[8] The first denial letter related to the disputed treatment plan is dated August 31, 2015. In that letter, the respondent indicates that "an insurer is liable to pay attendant care benefits […] on behalf of an insured person who sustains an impairment as a result of an accident if the impairment is **NOT** a Minor Injury" (emphasis in original). As discussed below, in submissions the parties disagreed with whether the treatment plan was for an attendant care assessment or occupational therapy.

[9] The respondent goes on to state that the applicant's injuries appear to be treatable within the MIG and that a s.44 insurance examination is required. The respondent also includes the following in a text table indicating the medical reason as: "Upon review of the minor injury guideline and the treating practitioner's medical opinion, we have concluded the health practitioner has not provided compelling evidence the impairment sustained is not predominantly a minor injury."

[10] The second denial letter, dated June 20, 2016, was provided after the applicant had attended a s.44 insurance examination with Dr. Khaled. The denial letter addresses entitlement to the disputed treatment plan and another one not included in this claim. In the denial, the respondent states that the assessor reviewed the treatment plans and determined the treatments recommended are not reasonable and necessary from the injuries sustained in the motor vehicle accident. The letter is silent as to whether the applicant's injuries are subject to the MIG.

Reason(s) for denial

[11] On page 11 of his June 17, 2016 report, Dr. Khaled answers "Yes." to question 3 in response to whether the applicant's injuries are predominantly minor and treatable under the MIG. In his answer to question 3, Dr. Khaled also provides the definition of minor injury, his interpretation of whether it applies to the applicant and his assessment of whether the applicant suffers from a pre-existing condition. Dr. Khaled goes on to state that "The insured's injuries and their treatment are subject to The Minor Injury Guidelines."

[12] Question 4 inquires whether the treatment plan is reasonable and necessary. Dr. Khaled's answer is "Not applicable. As noted above, the insured's injuries are sprains and strains only without evidence of significant neurological orthopedic complications. These are to be considered minor injuries as per the Guidelines." I did not find that Dr. Khaled used the words "reasonable" or "necessary" anywhere in his report.

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[13] I find that the respondent relied on the application of the MIG when denying the treatment plan and not whether the treatment plan was reasonable and necessary. By stating "not applicable", Dr. Khaled in fact declined to assess whether the treatment plan was reasonable and necessary.

Is the medical reason provided sufficient?

[14] As I have found that the respondent relied on the application of the MIG when denying the treatment plan and not whether the treatment plan was reasonable and necessary, I agree with the applicant that the respondent had a duty to re-assess the treatment plan after the applicant was removed from the MIG on July 5, 2016. There is no evidence before me that the respondent re-assessed the disputed treatment plan after removing the applicant from the MIG.

[15] From the applicant's perspective, since being removed from the MIG, he has not been provided with a reason why the respondent has denied the disputed treatment plan.

[16] For the reasons above, I find that the respondent's notice was deficient because (i) it misstated Dr. Khaled's opinion, and (ii) it did not re-assess the treatment plan after the applicant was removed from the MIG. Therefore, the applicant is entitled to the disputed treatment plan pursuant to s. 38(11).

Is the treatment plan for occupational therapy or an attendant care assessment and report?

[17] In submissions, the parties disagreed whether the disputed treatment plan was for occupational therapy or an attendant care assessment and report. I find that the disputed treatment plan is for an attendant care assessment and report and not for occupational therapy. The goals of the treatment plan clearly indicate that the purpose is an assessment to evaluate the applicant's needs. In addition, the cost breakdown of the medical benefit does not specify any funds for services related to treatment.

[18] Ashley Kuchar, Occupational Therapist, provides the following details in "Plan Goals[2]" in the treatment plan. She indicates that the goal is an "In-Home Assessment to evaluate the client's in-home, attendant care needs, and needs for assistive devices." She indicates the functional goals are to "Return to activities of daily living, to facilitate safety and independence in his living environment, to identify his attendant care needs, in-home needs, and assistive devices." Finally, she indicates that progress will be evaluated by "An occupational in-home therapy assessment report and attendance (*sic*) care needs assessment (Form 1) will be submitted."

[19] Further, at page 5, in Part 12 "Proposed Goods or Services Requiring Insurer Approval", two items are listed that amount to the total of $2,000.00. The first item is Attendant care benefit determination – completion of Form 1 in the amount of $1,800.00. The second item is for documentation in the amount of $200.00. I do not find that there is any allocation of money for any treatment.

[2] Page 4, parts 9 a) and b), OCF-19 dated by Ashley Kuchar, OT.

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[20] For the reasons above, I find that the disputed treatment plan is for an attendant care assessment and report and not for occupational therapy.

ORDER

[21] The applicant is entitled to the treatment plan for an attendant care assessment and report in the amount of $2,000.00. Because I find that the benefit is payable, the applicant is entitled to interest pursuant to s.51 of the *Schedule*.

Released: June 18, 2018

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Anita Goela
Adjudicator

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