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: Syrovy vs. Aviva Insurance Company, 2021 ONLAT 19-012498/AABS

Released Date: 01/08/2021
File Number: 19-012498/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:

Zdeno Syrovy

Applicant

and

Aviva Insurance Company

Respondent

DECISION

ADJUDICATOR: **Jesse A. Boyce, Vice-Chair**

APPEARANCES:

For the Applicant: Alicia Stuart, Counsel

For the Respondent: Geoffrey Keating, Counsel

HEARD: **Via written submissions**

OVERVIEW

[1] The applicant was injured in an accident on July 3, 2015, and sought various benefits from the respondent, Aviva, pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010*[1] ("*Schedule*"). Aviva denied the benefit in dispute here on the basis of its determination that the benefit is not reasonable and necessary. The applicant disagreed and submitted an application to the Tribunal for resolution of the dispute.

ISSUES IN DISPUTE

[2] The following issues are in dispute:

i. Is the applicant entitled to $2,580.63 for physiotherapy services recommended by Prestige Total Rehab submitted to the respondent on October 26, 2017?

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

RESULT

[3] Pursuant to s. 38(11)2, the applicant is entitled to payment for the treatment plan in dispute in the amount of $2,580.63, plus interest under s. 51. The applicant is entitled to a s. 10 award in the amount of $250.00.

ANALYSIS

$2,580.63 for physiotherapy services

[4] The sole treatment plan in dispute is dated October 26, 2017 in the amount of $2,580.63, comprised of 12 weeks of physiotherapy, massage therapy, chiropractic, and hyperthermy treatment, plus the cost of completing the OCF-18. The goals of the plan include pain reduction, increased strength/range of motion, return to activities of normal living, and return to pre-accident work activities.

[5] The applicant asserts that Aviva did not provide a medical reason for its denial of the treatment plan, submitting that this improper denial is a recurring theme in all of his other claims. In a letter dated November 16, 2017, Aviva responded to the applicant's claim for the treatment plan in dispute as follows: "We have not approved this treatment plan as it has been over 2 years post accident and under

[1] O. Reg. 34/10, as amended.

normal course, injuries should have reached maximum medical recovery. No compelling medical evidence has been provided to justify continued need for the therapy recommended in the OCF 18." The applicant asserts that Aviva's reason fails to take the OCF-18 itself into consideration as medical evidence, refers to "no compelling evidence" where medical professionals have recommended this precise treatment course and submits that it is not clear what is meant by a "normal course" for his condition.

[6] Against this denial, the applicant submits that Aviva did not request an assessment of this treatment plan under s. 44 and, as a result, the denial lacks a proper medical or other reason and is therefore in violation of s. 38(8). The applicant submits that the remedy for violation of s. 38(8) lies in s. 38(11), which provides that if the insurer fails to give proper notice, the insurer is liable to pay the disputed benefits.

[7] In response, Aviva submits that the applicant did not include any authority to support his position that the denial was invalid and asserts that the denial clearly references a lack of compelling medical evidence. With respect to not conducting a s. 44 assessment, Aviva submits that the *Schedule* does not require same. With respect to the applicant's position that he was being held within the Minor Injury Guideline ("MIG"), Aviva argues that at no point did it rely upon the MIG in denying entitlement to the benefit. Further, Aviva relies on two Insurer's Examination reports from 2016 to demonstrate that the treatment proposed was not reasonable and necessary and submits that the applicant has not provided analysis to demonstrate that the proposed OCF-18 is reasonable and necessary.

[8] The requirement for medical reasons was explained in the Tribunal's reconsideration decision of *T.F. v. Peel Mutual Insurance Company*, 2018 CanLII 39373, in which Executive Chair Lamoureux stated, at para. 19:

> 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.

[9] In this case, I agree with the applicant that Aviva's notice did not provide a "medical reason" for its denial. Where injuries and recovery timelines are unique to each applicant, it is unclear to me what is meant by "normal course" and I agree that this would not be clear to the applicant, who is an elderly man. Further, there are no meaningful or specific details of the applicant's condition or injuries to explain the relevance of the two-year period referenced in the denial or why the adjuster believed that the applicant should have achieved maximal medical recovery. The denial does not even refer to a specific impairment—just "injuries"—which is also confusing because the medical records indicate the applicant has struggled with concussion issues, neck and shoulder injuries, chronic pain, as well as psychological and emotional issues post-accident. In this vein, it is unclear what injuries Aviva believes should have resolved after two years, or if its position was that all of the applicant's injuries should have resolved in that timeline, a position that is undermined by its subsequent approval of a chronic pain program.

[10] In submissions, Aviva points to its reports from 2016 to retroactively justify the denial, but the explanation of benefits letter itself does not even bother to refer to a report or medical opinion of any kind—let alone the 2016 reports—nor does the letter demonstrate that the applicant's claim has been substantively considered against his medical file in arriving at the denial decision. In my view, the requirements to satisfy s. 38(8) are not particularly high for an insurer, but I do find that satisfaction requires some specificity in the medical or other reasons. I find Aviva's boilerplate notice to the applicant did not meet this minimum requirement.

[11] For these reasons, I find Aviva's explanation of benefits letter denying the treatment plan in dispute did not satisfy the requirements of s. 38(8) and, on the evidence, I was not directed to a subsequent notice that cured the denial in dispute. Accordingly, as the MIG is not applicable, only the consequences of s. 38(11)2 are triggered, meaning Aviva shall pay for the treatment plan in the amount of $2,580.63, plus interest under s. 51.

[12] For completion, had I not determined that the notice was deficient under s. 38(8), the applicant had the onus to demonstrate that the benefit in dispute is reasonable and necessary. To satisfy his burden, the applicant must demonstrate that the treatment goals, as identified, are reasonable, that the treatment goals are being met to a reasonable degree and that the overall cost of achieving these goals is reasonable, on a balance of probabilities. On the evidence, given his age and the duration of his injuries, as well as the continuous and contemporaneous documentation of his pain complaints, I find the treatment

plan to be reasonable and necessary because the goals and the costs associated with same are reasonable.

Section 10 Award

[13] The applicant seeks an award under s. 10 of O. Reg. 664, submitting that Aviva unreasonably withheld the payment of benefits, did not provide a proper denial and held the applicant within the MIG. Under s. 10, the Tribunal may award up to 50% of the total benefits payable if it determines that the insurer unreasonably withheld or delayed the payment of benefits. While the MIG issue is not before the Tribunal, I find an award of $250.00, plus interest, is appropriate, representing ~10% of the total benefits in dispute.

[14] The deficient notice under s. 38(8) triggered the consequences of s. 38(11)2. I find this award is appropriate in order to provide deterrence against Aviva's vague and largely unhelpful denial response to the treatment plan in dispute. I find that Aviva's denial did not contain specific details about the applicant's condition, failed to include meaningful information that would assist an elderly applicant in understanding the reason for the denial and, ultimately, delayed the payment of treatment that may have proven beneficial in his recovery.

ORDER

[15] The applicant is entitled to payment for the treatment plan in dispute in the amount of $2,580.63, plus interest under s. 51. The applicant is entitled to a s. 10 award in the amount of $250.00.

Released: January 8, 2021

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Jesse A. Boyce
Vice Chair