Citation: Alfajora v. Aviva General Insurance, 2023 ONLAT 20-012412/AABS

Licence Appeal Tribunal File Number: 20-012412/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:

Diana Alfajora

Applicant

and

Aviva General Insurance

Respondent

DECISION

VICE-CHAIR: **Brett Todd**

APPEARANCES:

For the Applicant: Rajiv Kapoor, Paralegal

For the Respondent: M. Jennifer Cosentino, Counsel

HEARD BY WAY OF WRITTEN SUBMISSIONS

OVERVIEW

[1] Diana Alfajora (the "applicant") was involved in a motor vehicle accident on April 2, 2018 and sought benefits pursuant to the *Statutory Accident Benefits Schedule – Effective September 1, 2010 (including amendments effective June 1, 2016)* (the "*Schedule*"). Aviva General Insurance (the "respondent") denied a number of treatment plans. The applicant submitted an application to the Licence Appeal Tribunal – Automobile Accident Benefits Service (the "Tribunal") for resolution of the dispute.

ISSUES IN DISPUTE

[2] The following issues are in dispute:

1. Is the applicant entitled to $2,200.00 for a chronic pain assessment, recommended by Novo Medical Services Inc. in a treatment plan/OCF-18 dated January 16, 2020?

2. Is the applicant entitled to $2,850.02 for assistive devices, recommended by Novo Medical Services Inc. in a treatment plan/OCF-18 dated April 24, 2020?

3. Is the applicant entitled to $2,684.62 ($3,641.09 less $956.47 approved) for psychological services, recommended by Novo Medical Services Inc. in a treatment plan/OCF-18 dated September 9, 2020?

4. Is the applicant entitled to $117.60 for assistive devices submitted in an Expenses Claim Form/OCF-6 dated November 4, 2020?

5. Is the respondent liable to pay an award under s. 10 of O. Reg. 664 because it unreasonably withheld or delayed payments to the applicant?

6. Is the applicant entitled to interest on any overdue payment of benefits pursuant to s. 51 of the *Schedule*?

RESULT

[3] I find that:

i. The applicant is not entitled to the chronic pain assessment treatment plan as she has not demonstrated it to be reasonable and necessary. It follows that she is also not entitled to interest.

ii. The applicant is not entitled to the assistive devices treatment plan or the assistive devices expenses, as she has not demonstrated them to be reasonable and necessary. Accordingly, she is also not entitled to interest.

iii. The applicant is entitled to the remaining unapproved amount of the psychological services treatment plan, plus interest, as she has demonstrated it to be reasonable and necessary and because the respondent has acted in contravention of s. 38(8) of the *Schedule*.

iv. The respondent is not liable to pay an award.

PROCEDURAL ISSUES

[4] In submissions, the respondent raised the following procedural issues about late disclosure of evidence by the applicant and the applicant's addition of an award claim in submissions that was not part of the Case Conference Report and Order ("CCRO") dated April 8, 2021 that set this matter down for a hearing.

Has the applicant submitted late evidence that was not properly disclosed?

[5] I do not find that the applicant has prejudiced the respondent with the submission of evidence after the deadline established for production disclosure in the CCRO.

[6] In its written submissions, the respondent requests that the Tribunal exclude the applicant's evidence submitted in Tabs 3, 4, 7, 10, 12, 13, and 14, as it was submitted after the deadline for productions in the CCRO. These tabs were served on the respondent on July 22, 2022 (Tabs 3, 7, 10, and 12), July 25, 2022 (Tab 4), and August 2, 2022 (Tabs 13 and 14), even though the CCRO set the final date for disclosure by both parties as July 18, 2022.

[7] The applicant refutes these assertions in reply submissions. She notes that Tab 7 was previously submitted on July 27, 2020 and March 31, 2021; Tabs 13 and 14 were previously submitted on March 31, 2021; Tabs 3, 10, and 12 were submitted just two days after the disclosure deadline; and Tab 4 was submitted just five days after the disclosure deadline. The applicant denies that it submitted these documents intentionally late and rejects any accusations of a procedural ambush. She also notes that the respondent has not demonstrated how it was prejudiced by the late disclosures.

[8] I agree with the applicant. Pursuant to ss. 23(1) and 25.0.1 of the *Statutory Powers Procedure Act* and paragraph #14 of the CCRO in question, it falls within my discretion to strike evidence that has not been disclosed according to the

deadlines set in a CCRO. However, I am prepared to admit the submissions in question into evidence. Even if the respondent is technically correct in its assertion that the tabs in question were submitted late, the contravention of the CCRO is a minor one involving just a few days. Also, some of the tabs being challenged by the respondent seem to consist of documents that were previously submitted to the insurer. Lastly, the negligible impact of such contraventions is outweighed by the consumer protection mandate of the *Schedule*, which is best served by hearing all submissions from applicants whenever reasonable and whenever possible.

[9] To sum up, I do not agree that the respondent has been prejudiced by the late submission of the tabs that have been challenged here. As a result, I admit these tabs as noted above into evidence and accord them whatever weight that I deem appropriate in the context of rending my decision.

Is the applicant entitled to add a claim for an award?

[10] The issue of an award claim pursuant to s. 10 of O. Reg. 664 is added to the issues in dispute for the following reasons.

[11] While the applicant did not raise an award claim during the case conference, she submits that she can add this issue at any time. She holds that the respondent failed to properly assess her claim as new medical information was provided and therefore unreasonably withheld and delayed the payment of benefits. The applicant seeks an award of 50% of the amount of all treatment plans in dispute.

[12] The respondent notes that the applicant should have provided prior notice and particulars of the award issue in advance of submissions. Aviva provides no argument beyond this, however, and then proceeds to state its defense on the award claim.

[13] I agree with the applicant, as there is no section of the *Schedule* or the *Rules* that requires an award to be included as part of a Tribunal application. In addition, there are no provisions that prevent me from adding an issue such as an award, even at this stage of the proceeding. I also do not find that the respondent has been prejudiced, as it had the opportunity to address the issue of the award claim—and did so—in its written submissions.

[14] For the reasons explained above, I have added an award claim to the list of issues in dispute.

Have both parties breached the CCRO due to the length of their written submissions?

[15] In short, yes.

[16] In written submissions, both parties complain about written submissions. The respondent notes that the applicant improperly formatted its submissions with extra-wide margins and not fully double-spacing its text, in contravention of the CCRO. As a result, it requests the Tribunal's indulgence in submitting 13 pages for its own written argument, more than the CCRO order allowed at 12 pages.

[17] The applicant writes in reply submissions that the respondent actually submitted 14 pages. She claims that this made the respondent's objections moot and further adds that the CCRO did not refer to page margins, just the number of pages, so her written submissions are in accordance with the order.

[18] Both parties have made submissions in contravention of both the specificity and the spirit of the CCRO. The applicant's initial submissions are not within the standard margins for documents, the font size appears to be smaller than the 12-point prescribed by the CCRO, and the text does not seem to have been fully double-spaced. Her reply submissions feature text that is nearly single-spaced and a full extra page beyond the maximum specified in the CCRO. The respondent submitted 14 pages to the bottom of the last page, two more than that mandated in the order.

[19] While I am still choosing not to use the discretion allowed me pursuant to ss. 23(1) and 25.0.1 of the *Statutory Powers Procedure Act* and paragraph #14 of the CCRO in question and will consider the full length of each party's written submissions, this should not be viewed as tacit acceptance of such blatant contraventions of the Tribunal's order. Both parties—who are experienced with submissions to this Tribunal—need to be aware that this sort of misconduct risks the potential exclusion of their submissions and that they must act in accordance with Tribunal orders in the future. If they seek to vary written submission page limits, they need to file a timely Notice of Motion in compliance with Rule 15 of the *Common Rules of Practice & Procedure* of this Tribunal, not submit whatever length and format of submissions that they prefer.

[20] Accordingly, albeit somewhat reluctantly, I accept the entirety of the applicant's and the respondent's written submissions into evidence.

ANALYSIS

The Treatment Plans and Expense Form

[21] To be entitled to a treatment plan under s. 15 and 16 of the *Schedule*, the applicant bears the burden of demonstrating on a balance of probabilities that the benefit is reasonable and necessary as a result of the accident. The applicant should identify treatment goals, how these goals would be met to a reasonable degree, and that the overall costs of achieving them are reasonable.

[22] As with treatment plans, entitlement to expenses also falls under s. 15 and 16 of the *Schedule*. The applicant similarly bears the burden of demonstrating on a balance of probabilities that the expenses are reasonable and necessary as a result of the accident.

[23] The treatment plans and the expense form in dispute are as follows:

i. A chronic pain assessment in the amount of $2,200.00 dated January 16, 2020 and completed by Tajedin Getahun, orthopaedic surgeon, of Novo Medical Services Inc. Injuries and sequelae identified in this plan include whiplash associated disorder ("WAD 2"), sprain and strain of the thoracic and lumbar spine, sprain and strain of the shoulder and sacroiliac joints, shoulder bursitis, rotator cuff syndrome, other chronic pain, tension-type headache, sleep disorders, and psychological and behavioural disorders. The plan recommends that the chronic pain assessment be conducted in order to arrange a pain management program for the applicant.

ii. A treatment plan for assistive devices in the amount of $2,850.02 dated April 24, 2020 and completed by Remik Zakrzewski, occupational therapist, and Nazila Isgandarova, social worker, of Novo Medical Services Inc. Injuries listed here are identical to those noted above. This plan recommends the purchase of a TENS unit, TENS accessories, a footrest, an electric heating pad, and an ergonomic keyboard, mouse, mouse pad, and office chair to assist the applicant in her workplace through pain reduction and aiding her in increased strength and improved range of motion.

iii. An expense form for assistive devices in the amount of $117.60 dated November 4, 2020. It includes the cost of a grip training kit, resistance bands, an ice pack for hot and cold therapy, and a therapy foam roller. These items were purchased directly by the applicant to assist with core strengthening and daily exercises to be done at home to augment

physical therapy. Proof of these purchases was provided in the applicant's submissions.

iv. A treatment plan for psychological services in the amount of $3,641.09 dated September 9, 2020 and completed by Dr. Leon Steiner, psychologist, and Hidayatullah Sherzad, psychotherapist, of Novo Medical Services Inc. This plan recommends 12 one-hour sessions of cognitive behavioural therapy along with a "communication with others" session, and includes additional fees for a progress report and pre- and post-session preparation. A return to pre-accident level of psychological functioning is the primary goal listed on this plan.

[24] The applicant relies on the following to demonstrate that these three plans are reasonable and necessary:

a) clinical notes and records ("CNRs") of Dr. Mary El Sabawy, family physician;

b) a prescription medication summary;

c) treatment records from Pain Care Clinics and Novo Medical Services Inc.;

d) an s. 25 psychological assessment report completed by Dr. Steiner dated June 16, 2020;

e) a psychotherapy progress report completed by Mario Lourenco, psychotherapist, dated December 4, 2021; and

f) an s. 25 job-site assessment report completed by Karen Quan, registered kinesiologist, under the supervision of Dr. Amir Owliaei, chiropractor, and dated February 1, 2020.

[25] In response, Aviva argues that the plans have not been demonstrated to be reasonable and necessary. In addition, the respondent challenges the causation of the applicant's injuries with regard to the latter two treatment plans, as these plans were submitted after the applicant was involved in a second auto accident on March 6, 2020. The respondent relies mainly on the following s. 44 insurer's examination ("IE") reports:

a) a musculoskeletal assessment report completed by Dr. Michael Hanna, family doctor, dated October 13, 2020, along with a clarification letter that he added on October 23, 2020, and a paper review dated April 21, 2021;

b) a psychological assessment report completed by Dr. Pushpa Kangaratnam, psychologist, dated September 28, 2020, and a paper review dated October 13, 2020;

c) a musculoskeletal assessment report completed by Dr. Lawrence (Todd) Walters, family physician, dated September 14, 2021; and

d) an occupational therapy assessment report completed by Rasul Kassam, occupational therapist, dated September 14, 2021.

[26] Below, I address the treatment plan for the chronic pain assessment, followed by the plan and expenses for assistive devices, and lastly the plan for psychological services.

Is the applicant entitled to the chronic pain assessment treatment plan?

[27] First, I find that any contraventions of s. 38(8) of the *Schedule* by the respondent with regard to its denial of the chronic pain assessment treatment plan were cured before any expenses were incurred. Accordingly, the applicant is not entitled to this plan on this basis.

[28] The applicant argues that the respondent breached s. 38(8) of the *Schedule* by submitting its denial notice late and without a proper explanation. This section of the *Schedule* states that an insurer shall send notice of such a denial to the applicant within 10 business days after it receives the treatment plan in question, and that this notice is to include the "medical reasons and any other reasons" regarding why the insurer is denying the plan in whole or in part. The applicant further argues that this triggers s. 38(11)(2), which requires that an "insurer shall pay for all goods, services, assessments and examinations described in the treatment and assessment plan that relate to the period starting on the 11th business day after the day the insurer received the application and ending on the day the insurer gives a notice described in subsection (8)."

[29] I agree with the applicant in regard to timing. She has submitted sufficient evidence that the treatment plan was submitted on February 18, 2020. The respondent has not provided proof that its denial notice was sent within 10 business days pursuant to s. 38(8) of the *Schedule*. All it has included in submissions is its explanation-of-benefits ("EOB") denial letter dated February 28, 2020, with no accompanying evidence of how or when this correspondence was sent to the applicant, to prove that it met the timeline established in the *Schedule*, which required the applicant to be notified by March 3, 2020.

[30] However, I disagree with the applicant on her claim that insufficient reasons were provided for the denial, and find that the respondent did not contravene s. 38(8) here. The EOB letter dated February 28, 2020 made a number of requests of the applicant via Novo Medical in accordance with s. 33(1)(1) of the *Schedule* to determine the applicant's entitlement to this benefit. No evidence has been submitted by the applicant demonstrating that these questions were ever answered, let alone within 10 business days as prescribed in s. 33(1). As a result of the applicant's failure to reply, the respondent did not have enough information to make a determination on this benefit. As a result, I cannot fault the respondent for shortcomings with regard to the "medical and any other reasons" provision of s. 38(8).

[31] Regardless, the respondent cured the deficient notice before this treatment plan was incurred (there is actually no evidence that it was ever incurred), with subsequent EOB letters dated June 29, 2020 and October 16, 2020. Both of these notices made specific referrals to the IE reports of Dr. Hanna noted above, which satisfies me that the notice provisions were fulfilled pursuant to s. 38(8). A treatment plan needs to be incurred *before* a deficient notice is cured to trigger s. 38(11)(2), in accordance with the Divisional Court decision of *Aviva General Insurance Company v. Vesna Catic*, 2022 ONSC 6000. As this did not happen here, it follows that the applicant is not entitled to the treatment plan in question on this procedural basis.

[32] Second, I find that the applicant is not entitled to the chronic pain assessment treatment plan as she has not demonstrated it to be reasonable and necessary. It follows that she is also not entitled to interest.

[33] I have significant concerns with the applicant's medical evidence, particularly in regard to the lengthy delay between the accident and the applicant seeking treatment. The applicant did not mention the accident to her family doctor, Dr. El Sabawy, until an appointment on August 20, 2019, more than 16 months after the accident occurred on April 2, 2018. Moreover, the applicant did not mention the accident to Dr. El Sabawy at any of her other post-accident appointments in 2018 and 2019. She even failed to mention the accident at an appointment with Dr. El Sabawy on April 23, 2018, just a few weeks after the accident. Even Dr. El Sabawy seemed to find her patient's reticence on disclosing the accident to be surprising, as she wrote in her notes from the appointment on August 20, 2019 that she saw the applicant twice in 2018 yet she never "mention[ed] anything about this MVA."

[34] In addition, Dr. El Sabawy reported the applicant as telling her at the August 20, 2019 appointment that she did not report the accident to her doctor or to her insurance company at the time that it happened as she was “not feeling bad” and felt that she would be “ok.” She told Dr. El Sabawy at this appointment that she had since developed neck, left shoulder, and low back pain after starting a new administrative job in a law office, however, and also that she was scared when driving and had developed post-traumatic stress as a result of the accident.

[35] Other medical treatment was sought out even later, which I find additionally problematic. The applicant did not submit a Disability Certificate/OCF-3 until September 28, 2019. This form, which was completed by Dr. Arash Saleki, chiropractor, lists a number of injuries including whiplash associated disorder (“WAD 3”) with complaint of neck pain and neurological signs; chronic sprain and strain of the thoracic and lumbar spine; chronic sprain and strain of the shoulder joint; chronic sprain and strain of the sacroiliac joint; shoulder bursitis; rotator cuff syndrome; other chronic pain; tension-type headache; sleep disorders; and psychological and behavioural factors. All of these issues were cited as the direct result of the accident, even though it took place some 17 months previously and even in the absence of objective medical evidence during that time linking these symptoms to the accident.

[36] All of this, to me, raises valid questions of causation. The applicant told Dr. El Sabawy that she was essentially fine after the accident to the point where she sought out no treatment whatsoever for 17 months, but then began experiencing pain in her neck, left shoulder, and lower back after starting a new administrative job. Taken together, these two factors make it impossible for me to determine that the applicant would not have experienced this pain—and made a chronic pain assessment reasonable and necessary—but for the accident.

[37] Further, the objective medical evidence does not support the need for a chronic pain assessment. X-rays of the applicant’s left shoulder and back taken at Credit Valley Hospital immediately after the accident on April 2, 2019 did not reveal any fractures. She was diagnosed with whiplash and advised about physical therapy and the use of over-the-counter pain medication. None of the diagnostic imaging ordered by Dr. El Sabawy after the August 20, 2019 appointment (x-rays of the cervical spine, lumbar spine, left shoulder, sacrum and coccyx, pelvis, and sacroiliac joints; an ultrasound of the left shoulder) revealed anything remarkable. An MRI report of the applicant’s left shoulder dated March 18, 2020 noted no significant abnormalities aside from the suspicion of a healed full-thickness tear of the biceps tendon (no evidence has been submitted to substantiate these suspicions, or that this was connected to the subject accident). An MRI report of

the applicant's lumbar spine dated July 6, 2020 indicated a minor disc bulge, but nothing else remarkable or attributed to the subject accident.

[38] I prefer Dr. Hanna's IE musculoskeletal examination report and subsequent paper review. These documents are the most thorough before me, given his extensive review of medical documentation, and they are the only ones that speak directly to this treatment plan. Granted, Dr. Hanna's reports focus on the Minor Injury Guideline ("MIG") that the applicant was subsequently removed from due to psychological sequelae, but I assign them significant weight as they still contain an assessment of the applicant's overall physical condition and the possibility of chronic pain. Dr. Hanna found the applicant to have sustained soft-tissue injuries in the accident that had since resolved given that more than two years had passed between the accident on April 2, 2018 and the in-person examination on July 29, 2020. He also concluded that the applicant did not present any of the symptoms of chronic pain and therefore did not warrant a chronic pain assessment. I see no reasons to doubt Dr. Hanna's analysis or his conclusions. They are quite comprehensive and, even more importantly, they align with the other objective medical evidence before me such as the CNRs of Dr. El Sabawy and the diagnostic imaging reports.

[39] I do not agree with the applicant's challenge of Dr. Hanna's reports with reference to the psychological IE report of Dr. Kanagaratnam. In submissions, the applicant claims that Dr. Hanna ignored this psychological report in its entirety. The applicant further claims that Dr. Hanna ignored specific notations by Dr. Kanagaratnam that the applicant was withdrawing from social and recreational activities and had shown a dependance on medical practitioners, which both can support a claim of chronic pain.

[40] However, this assertion is only partially accurate. Dr. Hanna did not review Dr. Kanagaratnam's report, which is not entirely surprising as psychology is not his field of expertise. But Dr. Kanagaratnam actually devoted little space in her report to these issues, did not note any significant issues or impairments due to chronic pain, and qualified all related comments with multiple notations of how the applicant told her that all of her symptoms worsened after a second auto accident that took place on March 6, 2020. By this report, it is hard to determine what injuries were caused by the subject accident and what were caused by the second accident, although I conclude from the comments of the applicant to Dr. Kanagaratnam that she encountered significantly more psychological issues after the second accident. At any rate, I cannot criticize Dr. Hanna for not referencing this report when he is not professionally qualified to comment on psychological

matters, and, in my opinion, the report does not support suspicions of chronic pain as a result of the subject accident.

[41] For all of the reasons noted above, I find that the applicant has not demonstrated the chronic pain assessment treatment plan to be reasonable and necessary. She is not entitled to this plan, or interest.

Are the treatment plan and expenses form for assistive devices reasonable and necessary?

[42] I find that the applicant is not entitled to the treatment plan or the expenses form for assistive devices as she has not demonstrated either to be reasonable and necessary. It follows that she is also not entitled to interest.

[43] Much of my reasoning follows the same train of thought as expressed above. Again, I have significant concerns about the timing of both this treatment plan and the expenses form, which were submitted over two years post-accident. They were also not submitted until after the applicant was involved in the second accident on March 6, 2020. This again raises questions about causation, at least in my mind, especially with regard to the treatment plan, which was submitted on April 24, 2020, just weeks after the second accident. Granted this could well be coincidental. Still, the fact remains that the plan and expense form were both submitted far closer to the applicant's second accident than the first one.

[44] Further, I find the applicant's medical evidence supporting both the plan and the expenses to be unpersuasive. This evidence consists largely of prescriptions from Dr. El Sabawy and the results of an s. 25 job-site assessment conducted on February 1, 2020. Again, both the prescriptions and the assessment are dated in 2020, two years and more after the subject accident. The prescriptions from Dr. El Sabawy are dated November 3, 2020, some 31 months after the subject accident took place on April 2, 2018, and eight months after the second accident. The job-site assessment (which assessed two jobs, as the applicant worked as a nanny and as a law clerk post-accident) took place before the second accident, but still came 22 months after the subject accident. The long gap between the subject accident and this report makes it impossible for me to conclude that these assistive devices were required as a direct result of the subject accident.

[45] I also prefer the s. 44 IE report and written addendum of Dr. Hanna. As I have already noted above when addressing the chronic pain assessment treatment plan, this is the most thorough medical evidence before me regarding the overall physical health of the applicant. Correspondingly, I assign significant weight to his reports and conclusions that the applicant suffered soft-tissue injuries in the

accident and displayed no loss of strength or reduced range of motion that would necessitate the use of the equipment listed in the OCF-18.

[46] In addition, I do not agree with the applicant's contention that the respondent contravened s. 38(8) of the *Schedule* in its denial of the assistive devices treatment plan, for similar reasons to that noted above with this same argument regarding the chronic pain assessment. I concur with the applicant in that the respondent has not provided proof that its denial letter dated March 7, 2020 was submitted according to the timeline prescribed by the *Schedule*. But the applicant has not provided proof that she responded to the additional information that was requested by the insurer in this letter, pursuant to s. 33 of the *Schedule*.

[47] I also find that the respondent cured any possible deficient notice in its correspondence dated June 29, 2020 and July 6, 2020, that noted the lack of response to the questions asked earlier and arranged the s. 44 IE with Dr. Hanna. Furthermore, the applicant has not provided evidence that any part of this treatment plan was ever incurred, which as I have noted above is, in my view, a necessary component to find that an applicant is entitled to a treatment plan due to the decision rendered in *Aviva General Insurance Company v. Vesna Catic*.

[48] In short, the applicant has not demonstrated either the treatment plan or the expenses claim form for assistive devices to be reasonable and necessary as a direct result of the subject accident. As a result, the applicant is not entitled to the treatment plan or the expenses, or interest.

Is the psychological services treatment plan reasonable and necessary?

[49] I find that the applicant has established that the treatment plan for psychological services is reasonable and necessary. I also find that the respondent has contravened s. 38(8) and not provided sufficient reasons for the partial denial of this plan. Therefore, she is entitled to the remaining unapproved portion of this plan, plus interest on any incurred amount.

[50] Medical evidence submitted by both parties show that the applicant experienced psychological sequelae as a result of the accident. Dr. Steiner diagnosed the applicant with post-traumatic stress disorder ("PTSD"), major depressive disorder, generalized anxiety disorder, somatic symptom disorder, and a specific driving phobia in his s. 25 psychological assessment report dated June 25, 2020, all as a direct result of the subject accident. He recommended 12-16 sessions of cognitive behavioural psychotherapy over three to four months. This is what was listed in the treatment plan in dispute (also authored by Dr. Steiner with the

assistance of Hidayatullah Sherzad, psychotherapist) along with additional fees for a progress report and pre- and post-session preparation.

[51] Dr. Kanagaratnam largely agreed with this assessment in her psychological IE report, diagnosing the applicant with major depressive disorder (moderate with anxious distress), somatic symptom disorder, and PTSD including features of a vehicular phobia. This resulted in the applicant being removed from the MIG for psychological reasons. In a follow-up paper review of the specific treatment plan at issue, Dr. Kanagaratnam found this OCF-18 to be reasonable and necessary with the exception of line three for treatment planning and line six for 12 sessions of pre- and post-therapy preparation at 0.5 hours each. Aviva partially approved this treatment plan as a result of Dr. Kanagaratnam's paper review, although only to a maximum amount of $956.47, in a letter dated October 16, 2020.

[52] However, neither Dr. Kanagaratnam nor Aviva specified detailed reasons for the partial denial. The psychologist noted that "planning and preparation are not considered as billable services and should be completed as part of the treatment service," a comment that to me is at least somewhat outside of her medical expertise. Aviva did not even go this far with its October 16, 2020 letter, which noted that Dr. Kanagaratnam had determined in her IE report that the plan in question was partially reasonable and necessary and the insurer would pay a maximum of $956.47. There was no further explanation of why this number was chosen and no breakdown of what would be paid and what would not be paid. As a result, I prefer the more informative report of Dr. Steiner, which also connects directly to the treatment plan recommendations.

[53] I also find that the respondent has not fulfilled the requirements of s. 38(8) of the *Schedule* with regard to providing proper notice about the denial, a notice that unlike the other issues previously addressed was not subsequently cured by the respondent. Simply providing a number with no breakdown or indeed any additional information is insufficient, in my view, and leaves the applicant without enough information with which to make an informed decision about her options regarding future treatment or an appeal to the Tribunal. Also, unlike the similar issues noted above with the other treatment plans, there is no evidence that the respondent cured this insufficient notice.

[54] For both of the above reasons, the applicant is entitled to the full amount of this treatment plan plus interest on any incurred amount as applicable.

Award

[55] I find that the respondent has not unreasonably withheld or delayed payments to the applicant and is not liable to pay an award.

[56] As noted above, in the applicant's written submissions she requested the addition of an award claim to the issues in dispute. Pursuant to s. 10 of O. Reg. 664, the Tribunal may award up to 50 per cent of the total benefits payable along with interest. Conduct warranting an award must rise beyond simply "getting it wrong." An insurer must be found to have behaved in an unreasonable fashion in its withholding of benefits, to the point where it has acted in an excessive, imprudent, stubborn, inflexible, unyielding, or immoderate manner.

[57] Any such award claim would have to be based on the way that Aviva handled the psychological treatment plan, as that is the only treatment plan in dispute that I find the applicant entitled to receive. And I see no evidence of misconduct on the part of the insurer here. Aviva sent the applicant to Dr. Kanagaratnam for an IE and she supported the applicant's claims to psychological sequelae and even partially approved this treatment plan. The insurer also referred the applicant back to Dr. Kanagaratnam for a paper review of the treatment plan in dispute. The only evidence of anything even slightly problematic is the lack of explanation offered by the psychologist in the paper review and in the subsequent denial letter, but I do not find that this rises to the level of being worth an award.

[58] For the above reasons, the respondent is not liable to pay an award.

ORDER

[59] I find that:

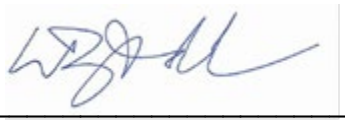
i. The applicant is not entitled to the chronic pain assessment treatment plan as she has not demonstrated it to be reasonable and necessary. It follows that she is also not entitled to interest.

ii. The applicant is not entitled to the assistive devices treatment plan or the assistive devices expenses, as she has not demonstrated them to be reasonable and necessary. Accordingly, she it also not entitled to interest.

iii. The applicant is entitled to the remaining unapproved amount of the psychological services treatment plan, plus interest, as she has demonstrated it to be reasonable and necessary and because the respondent has acted in contravention of s. 38(8) of the *Schedule*.

iv. The respondent is not liable to pay an award.

Released: June 28, 2023



Brett Todd
Vice-Chair