Citation: Singh v. Aviva Insurance Company, 2024 ONLAT 22-002759/AABS

Licence Appeal Tribunal File Number: 22-002759/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:

Varinderjit Singh

Applicant

and

Aviva Insurance Company

Respondent

DECISION

ADJUDICATOR: **Trina Morissette**

APPEARANCES:

For the Applicant: Tal Eshel, Counsel

For the Respondent: Jennifer Cosentino, Counsel

HEARD: In Writing

OVERVIEW

[1] Varinderjit Singh, the applicant, was involved in an automobile accident on April 8, 2017, and sought benefits pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010 (including amendments effective June 1, 2016)* (the "*Schedule*"). The applicant was denied benefits by the respondent, Aviva Insurance Company, and applied to the Licence Appeal Tribunal - Automobile Accident Benefits Service (the "Tribunal") for resolution of the dispute.

ISSUES

Preliminary Issue

[2] The preliminary issue is:

i. Is the applicant precluded from proceeding with his application for $2,460.00 for a psychological assessment in an OCF-18 submitted March 7, 2019 for failing to dispute the respondent's denial of the benefits within the two-year limitation period pursuant to s. 56 of the *Schedule*?

[3] I note that the Case Conference Report and Order indicates the plan noted above was submitted on March 7, 2017 and although neither party addressed it in their written submissions, the evidence in this matter indicates that the date was incorrectly noted and should be March 7, 2019. Regarding the same issue in dispute, the parties clarified in their written submissions that the preliminary issue to be decided in the amount of $2,460.00 is for a psychological assessment rather than psychological services.

The applicant is statute-barred from pursuing his claim for a psychological assessment in the amount of $2,460.00 (partially approved for $1,322.07).

[4] Section 56 of the *Schedule* sets out that an application under subsection 280(2) of the *Act* in respect of a benefit shall be commenced within two years after the insurer's refusal to pay the amount claimed. To trigger the running of the limitation period, the insurer must provide clear and unequivocal notice of a refusal to pay benefits. In *Smith v. Co-operators General Insurance Co.*, 2002 SCC 30 (CanLII), the Supreme Court of Canada articulated the requirements that an insurer must satisfy for there to be a proper denial of benefits: straightforward and clear language to inform a person of the dispute resolution process; language directed towards an unsophisticated person; identification of the

person's rights to dispute the denial; and the relevant time limits that govern that process.

[5] For the reasons that follow, I find the applicant did not submit his claim for the psychological assessment within the two-year limitation period after the respondent partially denied payment of the specified benefit.

[6] The onus is on the respondent to show that the two-year limitation period started to run when a proper denial was served on the applicant. The respondent submits that the applicant failed to appeal the denial within the two-year limitation period and relies on its letter dated May 8, 2019. The applicant did not provide any reasons for the delay. In his submissions, the applicant simply maintains that the treatment plan is reasonable and necessary.

[7] I find the letter from the respondent informing the applicant of the partial approval for the psychological assessment constitutes clear and unequivocal notice. In its letter dated May 8, 2019, the respondent informed the applicant that the OCF-18 submitted for a psychological assessment was partially approved in the amount of $1,322.07. The letter in question includes information on the applicant's right to dispute, notice of the two-year limitation period and reference to the treatment plan. Although the treatment plan referenced is dated March 3, 2019 and the actual treatment plan is dated March 5, 2019, this error is minor and has no impact on the result of whether proper notice was provided.

[8] Based on the evidence before me, I find that the partial denial occurred on May 8, 2019 and the applicant only notified the respondent of his intent to appeal this partial denial through the filing of his application with the Tribunal on March 7, 2022. The limitation period therefore ended on May 8, 2021 and the application was filed almost nine months after that.

[9] I therefore find that the applicant did not dispute the respondent's denial for a psychological assessment within the two-year limitation period. While this Tribunal has the authority under s. 7 of the *Licence Appeal Tribunal Act, 1999*, in accordance with the principles in *Fratarcangeli v. North Blenheim Mutual Insurance Company,* 2021 ONSC 3997 (Div. Ct.), to extend the time to file an appeal, the applicant bears the burden of persuading the Tribunal to exercise that discretion. Yet, as mentioned, the applicant made no submissions that might explain the delay. I therefore decline to exercise my discretionary power. Accordingly, the applicant is precluded from pursuing his claim for a psychological assessment in the amount of $2,460.00 (partially approved for $1,322.07) in accordance with s. 56 of the *Schedule*.

Substantive Issues

[10] The issues in dispute are:

i. Is the applicant entitled to $2,200.00 for physiotherapy proposed by Complete Rehab Centre in an OCF-23 submitted May 9, 2017?

ii. Is the applicant entitled to medical benefits and cost of examination expenses recommended by ALCAT Assessments Inc. in the following plans:

i. $4,920.00 for botox injections submitted January 22, 2021;

ii. $3,891.08 for occupational therapy submitted August 10, 2021;

iii. $2,200.00 for a neurological assessment submitted August 13, 2021; and

iv. $2,712.78 for psychological treatment submitted January 14, 2022?

iii. Is the applicant entitled to medical benefits recommended by Ruhani Physio and Wellness in the following plans:

i. $1,696.25 for physiotherapy submitted February 26, 2021 and

ii. $3,192.50 for physiotherapy submitted November 5, 2021?

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

RESULT

[11] I find that:

i. The applicant's claim for a psychological assessment in the amount of $2,460.00 is statute-barred due to his failure to dispute the benefit within the prescribed two-year limitation period, under s. 56 of the *Schedule*.

ii. The applicant is not entitled to any of the disputed treatment plans for services or assessments, nor the invoiced expenses in dispute.

iii. Since there are no benefits payable, no interest is payable.

ANALYSIS

The treatment plans and OCF-23 are not reasonable and necessary

[12] At issue are six treatment and assessment plans ("OCF-18s") and one treatment confirmation form ("OCF-23") from various service providers.

[13] To receive payment for a treatment and assessment plan under sections 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. To do so, the applicant should identify the goals of treatment, how the goals would be met to a reasonable degree and that the overall costs of achieving them are reasonable.

[14] The applicant submits that, as a result of the accident, he suffers from permanent and serious impairments of important physical, mental and psychological functions, including trauma to his head, neck, shoulders, back, hips and legs.

Physiotherapy services for $1,696.25 and $3,192.50

[15] The two treatment plans for physiotherapy services are not reasonable and necessary.

[16] The applicant submits that the treatment plans are reasonable and necessary and relies on the family physician's clinical notes and records, the applicant's diagnosis of sprain and strain of his lumbar spine and cervical spine in the OCF-18s, and a chronic pain syndrome diagnosed by Dr. Rosen following an assessment and chronic pain report dated July 15, 2020.

[17] Although the applicant submits that Dr. Rosen diagnosed the applicant with WAD-II, I note that her report notes a "possible WAD-II". In her report, Dr. Rosen recommends that the applicant resume physiotherapy and active exercise and adds that he should explore the option of aqua therapy, which she notes "has been very effective with patients suffering from chronic pain."

[18] In response, the respondent relies on two s. 44 physical medicine and rehabilitation specialist assessment reports, each prepared following receipt of the OCF-18s in issue. The first report was prepared by Dr. Ko, a physiatrist and physical medicine and rehabilitation specialist, dated March 19, 2021 and the second prepared by Dr. Oshidari, a physical medicine and rehabilitation specialist, dated July 6, 2022.

[19] I find the applicant has not demonstrated that the treatment plans are reasonable and necessary. While I agree with the applicant's submission that pain relief is a legitimate goal for treatment, the applicant reported that physiotherapy treatments obtained in the past only provided temporary relief of his significant pain for less than a day. Both Dr. Ko and Dr. Oshidari found that the applicant has sustained no impairment from a physical perspective and that the applicant has reached maximum medical improvement. Of note, the applicant reported to Dr. Oshidari that he had only achieved 20-25% improvement after five years of treatment which Dr. Oshidari opined to be indicative that treatment was no longer beneficial.

[20] In addition, although Dr. Rosen recommended aqua therapy to specifically address the chronic pain, the treatment plans in dispute list sessions of physiotherapy and sessions of physical rehabilitation, respectively. Neither treatment plan includes aqua therapy for pain relief as recommended by Dr. Rosen despite that the report was prepared in 2020 and therefore available.

[21] I find the reports prepared by Drs. Ko and Oshidari persuasive and the balance of the medical evidence tendered does not establish that additional facility-based treatment is reasonable and necessary pursuant to the *Schedule*.

Physiotherapy services in an OCF-23 for $2,200.00 (partial payment made with a remaining balance of $400.00)

[22] The CCRO identified the amount in dispute of the OCF-23 being $2,200.00 and the applicant's written submissions reiterate this amount. However, an Auto Insurance Standard Invoice (OCF-21), provided by Complete Rehab Centre and submitted by the respondent, confirms the services rendered were in the amount of $2,115.00, not $2,200.00. The applicant did not file a copy of the OCF-23 with the Tribunal.

[23] Through its written submissions, the respondent advised that it was no longer pursuing a s. 55 or a s. 56 defence for this issue in dispute. The respondent submits that, following receipt of the OCF-21, the respondent issued payment in the amount of $1,715.00 but stated that the balance of $400.00 appeared to be generic and not specific to the treatment the applicant would receive nor was it itemized. The payment of $1,715.00 and balance of $400.00 are supported by the Accounting Summary relied on by the applicant and filed with the Tribunal.

[24] I find the balance of the OCF-23 in the amount of $400.00 is not reasonable and necessary.

[25] The applicant failed to provide any submissions on how the remaining balance of $400.00 is reasonable and necessary. The applicant relies on correspondence from Complete Rehab Centre dated October 18, 2017 which the respondent submits is generic. This correspondence states:

> The following is a description of supplementary goods and services. They may include but are not limited to:
>
> Treatment services for the additional minor injuries arising from the same accident. That is, Multiple body parts being treated due to the insureds' multiple complaint areas. Available modalities include IFC, US, Laser, TENS, Acupuncture, cryo and thermotherapy (multiple body regions).
>
> Goods required for self directed exercise and/or pain management. Assistive devices required to maintain/return to work/school/home or personal activity (Theraband, gym ball, hot/cold packs, back support, lumbar roll, etc).
>
> Supportive interventions such as advice/education to deal with accident related psycho-social issues. Hurt vs Harm.

[26] I agree with the respondent that the explanation provided is generic. The explanation does not constitute recommendations for treatment required, nor does it address the goals of treatment, how the goals would be met to a reasonable degree or that the overall costs of achieving them are reasonable.

[27] I therefore find that the applicant has not satisfied his burden pursuant to the *Schedule* and the balance remaining of $400.00 is not reasonable and necessary.

Botox injections for $4,920.00

[28] The treatment plan for Botox injections is not reasonable and necessary.

[29] The applicant submits that the treatment plan is reasonable and necessary and relies solely on the chronic pain assessment report of Dr. Rosen dated July 15, 2020 who recommends this treatment amongst other recommendations. The applicant further submits that it is untenable to provide funding for a chronic pain assessment and not Botox injections because the injections flow from the chronic pain assessment.

[30] The respondent submits that sections 14, 15 and 16 of the *Schedule* were not meant to provide a catch-all approach to every recommendation made by all assessors involved in the accident benefits.

[31] I note that the applicant has not filed the OCF-18 with the Tribunal and makes no submissions on the information contained therein. I rely on *K.R. v Aviva Insurance Canada*, 2019 CanLII 22218 (ON LAT) and find that the applicant's failure to submit the treatment plan with her submissions makes it impossible for me to assess whether it is reasonable and necessary. Without this plan, I cannot review the specifics of the recommended treatment or the goals and costs, let alone assess them alongside the submitted medical evidence to decide if the treatment plan is reasonable and necessary.

[32] Each claim before the Tribunal must be evaluated on its own merits. Without the OCF-18 before the Tribunal and without any submissions on the merits of this specific treatment plan, I find the applicant has not met his burden. The treatment plan has not been demonstrated to be reasonable and necessary.

Psychological services for $2,712.78 (partially approved for $2,563.17)

[33] The CCRO identified the amount in dispute of the OCF-18 being $2,712.78 however, an Explanation of Benefits dated July 28, 2022 shows that the respondent partially approved the treatment plan in the amount of $2,563.17, leaving a balance in dispute of $149.61.

[34] As was the issue with the treatment plan for Botox injections, the applicant did not file the OCF-18 for psychological services. The applicant also did not provide any submissions on the remaining balance in dispute in the amount of $149.61. The applicant's submissions addressed almost exclusively the issue of the psychological assessment which I have already found to be statute-barred. The only submissions made with respect to the treatment plan for psychological services state that the respondent has approved funding for four separate treatment plans all contemplating psychological counselling of the same nature.

[35] Without the OCF-18 before the Tribunal and without any submissions on the merits of the goals and the cost of the treatment plan – more specifically the balance in dispute in the amount of $149.61 – I find the applicant has not satisfied his onus that the treatment plan is reasonable and necessary.

Occupational therapy services for $3,891.08 (partially approved for $1,147.90); and neurological assessment for $2,200.00

[36] The CCRO identified the amount in dispute of the OCF-18 being $3,891.08 however, an Explanation of Benefits dated July 26, 2022 shows that the respondent partially approved the treatment plan in the amount of $1,147.90, leaving a balance in dispute of $2,743.18.

[37] The applicant submits that there is an abundance of records of complaints within the medical documentation to support that the treatment plans in dispute are reasonable and necessary. Regarding the treatment plan for occupational therapy, the applicant relies primarily on a progress report by Dr. Jazayeri, psychotherapist, dated June 8, 2021 and a progress report by Ms. Rubin, occupational therapist, dated March 2, 2023 which indicates the applicant requires additional occupational therapy treatment.

[38] In support of his entitlement to the neurological assessment, the applicant relies on the chronic pain assessment report of Dr. Rosen in which the applicant reported experiencing headaches several times a day and the neurological complaints the applicant made to Ms. Bayan, occupational therapist.

[39] The applicant did not file either of the OCF-18s with the Tribunal. As previously noted, without these plans, I cannot review the specifics of the treatment that they recommend or the goals and costs, let alone assess them alongside the submitted medical evidence to decide if they are reasonable and necessary.

[40] I find that the applicant has not satisfied his burden. The treatment plans in dispute are not reasonable and necessary.

Interest

[41] Interest applies on the payment of any overdue benefits pursuant to s. 51 of the *Schedule*. There is no interest owing in this case because no benefits are payable.

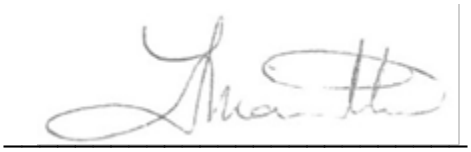
ORDER

[42] The applicant's claim for a psychological assessment in the amount of $2,460.00 is statute-barred.

[43] The applicant has not met his evidentiary burden to establish that the treatment plans in dispute are reasonable and necessary. As there are no benefits payable, the applicant is not entitled to interest.

[44] The application is dismissed.

Released: February 26, 2024



Trina Morissette
Adjudicator