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: Corpuz v. Aviva General Insurance, 2021 ONLAT 19-014198/AABS

Released Date: 02/01/2021
File Number: 19-014198/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:

Romel Corpuz

Applicant

and

Aviva General Insurance

Respondent

DECISION AND ORDER

VICE CHAIR: **Theresa McGee**

APPEARANCES:

For the Applicant: Lisa Bishop, Counsel

For the Respondent: Matthew Owen, Counsel

HEARD: **By way of written submissions**

REASONS FOR DECISION AND ORDER

OVERVIEW

[1] The applicant, R.C., was involved in an automobile accident on December 23, 2015, when the vehicle he was driving was rear-ended. He sought benefits pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010*[1] (the "*Schedule*").

[2] The respondent, Aviva General Insurance, denied the applicant certain benefits and he applied to the Licence Appeal Tribunal - Automobile Accident Benefits Service ("Tribunal") for a resolution of the dispute.

ISSUES IN DISPUTE

[3] I am to decide the following issues:

i. Is the applicant entitled to a medical benefit in the amount of $2,456.00 for chiropractic services recommended by Health-Pro Wellness in a Treatment and Assessment Plan (OCF-18) submitted March 7, 2019 and denied March 10, 2019?

ii. Is the applicant entitled to $1,997.29 for the cost of a Psychological Assessment recommended by Health-Pro Wellness in a Treatment and Assessment Plan (OCF-18) submitted April 18, 2016 and denied February 5, 2018?

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

iv. Is the applicant entitled to an award for unreasonably withheld or delayed payments under section 10 of Ontario Regulation 664?

RESULT

[4] The applicant has failed to demonstrate entitlement to the benefits he seeks. On a balance of probabilities, I find both the treatment and assessment in dispute not reasonable and necessary as a result of the accident. Since no benefits are owing, no interest is payable. There is no basis for an award.

[5] Conversely, the respondent is entitled to receive costs in the amount of $100.00.

[1] O. Reg. 34/10.

ANALYSIS

Accident-related injuries

[6] Six days after the accident, on December 29, 2015, the applicant was assessed at Health-Pro Wellness by Dr. Aliya Salayeva, Chiropractor. Dr. Salayeva completed a Disability Certificate (OCF-3) on the applicant's behalf, listing his injuries as whiplash associated disorder with neck pain and musculoskeletal signs, other sprain and strain of the cervical spine, strain and sprain of the thoracic spine, strain and sprain of other unspecified parts of the lumbar spine and pelvis, tension-type headaches, other sleep disorders, subluxation complex (vertebral), radiculopathy, and sprain and strain of the shoulder joint. In Part 7 of the Disability Certificate, ("Further Investigations or Consultations"), Dr. Salayeva indicated that a Psychological Assessment and Attendant Care Assessment were contemplated or required.

[7] One month later, on January 27, 2016, the applicant reported the accident to his family doctor, Dr. R. Atwal. Dr. Atwal's clinical notes from the visit are handwritten and appear to indicate, in one type of handwriting, (which I take to be that of clinical staff), "+ history of whiplash injury to the neck, + frequent episodes of dizziness, headache, neck pain and lower back pain". The remaining notes, which appear to be handwritten by Dr. Atwal (because they include a recommendation for motor vehicle accident rehabilitation and an order for an x-ray of the lumbar and thoracic spine), are otherwise illegible and have not been transcribed. It is unclear from the record whether x-rays were ever conducted, as the applicant has not tendered any diagnostic imaging reports.

The disputed Psychological Assessment

[8] On April 18, 2016, Health-Pro Wellness submitted a Treatment and Assessment Plan (OCF-18) completed by Dr. Fahimeh Aghamohseni on the applicant's behalf. The plan recommended a Psychological Assessment at a cost of $1,997.29. In the "Additional Comments" section of the plan, Dr. Aghamohseni appended the results of a "Pre-Screening Assessment" conducted the day the plan was prepared.

The sufficiency of the denial

[9] The parties' positions on what happened next diverge significantly. The applicant submits that the respondent first replied to the OCF-18 by requesting a Section 44 Insurer's Examination ("IE") on May 25, 2016, well outside the 10-business day timeframe prescribed by s. 38 of the *Schedule*. That response, the applicant

submits, contained no reasons for a denial of payment, and included information entirely unrelated to his claim. The applicant submits that the respondent did not properly request an IE until January 3, 2018 and did not provide a proper denial of the plan until February 5, 2018, nearly 21 months after the plan was submitted. It is the position of the applicant that the respondent stalled in rescheduling the IE.

[10] The respondent submits that the applicant falsely narrates the history of this claim. It submits that it initially replied to the treatment plan on April 25, 2016, within the time period prescribed by s. 38 of the *Schedule*. That initial notice denied the plan and requested an IE for May 19, 2016, the respondent submits, so that it could better evaluate the reasonableness and necessity of the plan in accordance with s. 44 of the *Schedule*.

[11] The respondent submits that the applicant failed to attend the May 19, 2016 IE. The notice sent on May 25, 2016, it submits, was clearly a second notice as it referred to the applicant's non-attendance at a previously scheduled IE. The respondent acknowledges that incorrect information was included in the second notice but that the treatment plan under consideration was clearly identified under the header "Explanation of Benefits".

[12] The respondent submits that the applicant was not in contact again until October 12, 2017, 17 months later. Up until that point, the respondent submits, the applicant failed to attend all IEs it requested. The respondent attempted to confirm the other benefits the applicant was seeking so that all of his claims could be properly investigated. It took the applicant a further two months to confirm the benefits he was seeking. At that point, the respondent scheduled the IE to determine the reasonableness and necessity of the proposed Psychological Assessment.

[13] Based on the evidence, I accept the respondent's account of the claim's history. I find that the respondent replied to the treatment plan on April 25, 2016, within the notice period required under the *Schedule*. The notice clearly indicates that the plan is not payable and requests an IE in accordance with s. 44 of the *Schedule*. The plan was properly denied pending the results of the IE.

[14] I find that the applicant failed to attend the IE scheduled for May 19, 2016, and that he failed to attend another IE with a psychologist that was scheduled for February 8, 2017. The applicant did not exercise his right of reply and has tendered no evidence to counter the respondent's submission that he did not reply to its notices until October 17, 2017. I have reviewed the correspondence presented by the parties and conclude that the applicant's characterization of the

21-month delay is inaccurate. The parties were evidently in communication regarding the scheduling of an IE to address the applicant's claim for an income replacement benefit. I attribute the lapse between the applicant's October 17, 2017 email and the respondent's February 5, 2018 denial to those negotiations.

The expense is not deemed incurred

[15] The applicant requests that the Tribunal find the Psychological Assessment deemed incurred in accordance with s. 3(8) of the *Schedule* on the grounds that the respondent unreasonably withheld or delayed payment. I have found that the respondent's denial of the proposed assessment was reasonable, and as such, the plan is not deemed incurred under the *Schedule*.

The applicant has not proven that the plan was reasonable and necessary

[16] The applicant has not discharged his onus of establishing the reasonableness and necessity of the disputed Psychological Assessment. There is no mention in the objective medical evidence of psychological injury as a result of the accident. There is no reference in Dr. Atwal's clinical notes and records to psychological concerns warranting investigation or treatment.

[17] The treatment plan itself is not evidence of the necessity of the proposed assessment, nor is the pre-screen assessment Dr. Aghamohseni included in the plan. The applicant submits that the OCF-3 and the OCF-18 are compelling evidence that a Psychological Assessment was warranted. It is well-established in the case law that contemporaneous corroborating medical evidence is required to establish entitlement to medical benefits: see *16-004549 v. Aviva General Insurance Company* and *17-004357 v. Aviva General Insurance*.[2] An applicant's evidentiary onus is not discharged by relying on the treatment plan itself.

[18] The pre-screen assessment report of Dr. Aghamohseni raises other evidentiary concerns. The respondent has tendered a pre-screen assessment report by Dr. Aghamohseni in respect of another insured person, dated May 14, 2012, redacted to remove all identifying information. Substantial portions of this report are replicated verbatim in the pre-screen assessment conducted for this applicant. The similarity between the reports is especially striking in that the author attributes quoted remarks to the two subjects that are identical, including the following:

[2] 2017 CanLII 63623 (ON LAT), 2018 CanLII 13152 (ON LAT).

i. [the subject] described the experience as “?intensely [*sic*] scary and upsetting. I was so scared.”

ii. Emotionally, [the subject] is very upset about his situation. He quotes: “It’s been hard. I feel completely down…”

iii. He would very much like to recover from this condition in which he feels “?stuck.” [*sic*] He expressed needing help but not knowing how to obtain it.

[19] Given the dates of the two assessments, I have significant doubt that the above quotations have been properly attributed to the applicant. The similarities between the applicant’s pre-screen assessment and the report authored four years prior undermine the reliability of Dr. Aghamohseni’s report as a whole. I therefore assign no weight to his findings and recommendations.

[20] By order of Adjudicator Thérèse Reilly dated May 26, 2020, the applicant had until October 2, 2020 to file reply submissions or give notice that no reply submissions would be filed. The applicant did not file by the deadline and, to date, has brought no motion for an extension of the deadline. The applicant has not attempted to counter the respondent’s submissions as to the weight of Dr. Aghamohseni’s report.

[21] Finally, I reject the applicant’s submission that the respondent’s request for a Psychology IE undermines its claim that such an assessment was not reasonable and necessary. Section 44 of the *Schedule* gives insurers a right to request IEs to assist in determining entitlement to claimed benefits, provided that requests are not made more often than is reasonably necessary. I have no basis to conclude that the request for the IE contravened this requirement.

The disputed chiropractic services

[22] The treatment plan for chiropractic services was submitted on March 7, 2019. On March 21, 2019, the respondent denied the plan, requesting an IE.

[23] The applicant submits that the reasons given for the denial were non-specific and failed to meet the notice requirements under s. 38 of the *Schedule*.

[24] The respondent submits that the reason given for the denial - that the proposed treatment was inconsistent with the diagnosis - was valid. The respondent submits the treatment plan was submitted nearly three years after the accident, and there was no formal diagnosis of any accident-related injury in the objective medical evidence.

[25] The applicant submits that there was more than enough evidence to support the reasonableness and necessity of chiropractic services at the time the plan was submitted. He submits that he had a history of diabetes and sciatica which were clear barriers to his recovery. The plan, he submits, was intended to achieve pain reduction and functional restoration, which are legitimate treatment goals.

[26] In respect of the disputed chiropractic services, the applicant has not met his evidentiary onus. He has not established the necessity of therapeutic intervention to treat an accident-related impairment at the time this treatment plan was submitted, three and a half years after the accident. While I am alive to the recommendation of Dr. Atwal that the applicant seek rehabilitation in January of 2016, there is no objective medical evidence before me to substantiate entitlement to this benefit in March of 2019. I find that the reasons given for the denial satisfy the notice requirements set out in the *Schedule*.

Award under Ontario Regulation 664

[27] The applicant submits that he is entitled to an award under s. 10 of Ontario Regulation 664. He submits that the respondent's failure to investigate his claims curtailed his access to treatment and was arbitrary, high-handed conduct that departed from the standards of behaviour expected of a sophisticated insurance company.

[28] There is no basis for an award. The applicant has failed to establish that the respondent unreasonably withheld or delayed the payment of benefits. He has not presented evidence to support his submission that the respondent engaged in conduct that was arbitrary or high-handed. The objective medical evidence fails to establish the reasonableness and necessity of the disputed treatment plans. The evidence does not show that the respondent failed to properly investigate the applicant's claim for either benefit. As I have found, the respondent properly requested IEs to do so.

COSTS

[29] Under Rule 19 of the Tribunal's Common Rules of Practice and Procedure, ("Common Rules"), the Tribunal may award costs where a party in a proceeding has acted unreasonably, frivolously, vexatiously, or in bad faith.

[30] Rule 19.5 stipulates that in deciding whether to order costs and the amount of costs to be ordered, the Tribunal shall consider all relevant factors including:

i. the seriousness of the misconduct;

ii. whether the conduct was in breach of a direction or order issued by the Tribunal;

iii. whether or not a party's behaviour interfered with the Tribunal's ability to carry out a fair, efficient, and effective process;

iv. prejudice to other parties; and

v. the potential impact an order for costs would have on individuals accessing the Tribunal system.

[31] The respondent seeks an award for costs in the amount of $1,000.00 on the grounds that the applicant acted vexatiously and in bad faith in this proceeding.

[32] Specifically, the respondent submits that the applicant misrepresented the procedural history of the claim for a Psychological Assessment and in so doing purposely misled the Tribunal. It submits that the applicant made deceitful submissions alleging a 21-month delay between the respondent's receipt and denial of the treatment plan. The respondent submits that the applicant tendered an email redacted to conceal the fact that his counsel was in contact with the adjuster during that period to arrange IEs for the applicant's other claims.

[33] The relevant portions of the applicant's submissions on the alleged 21-month delay are as follows:

> There was no proper explanation to the Applicant why the plan was denied until February 5, 2018. It was not until January 3, 2018 that the insurer provided the Applicant with a notice of IE assessment.[3]
>
> […]
>
> To be clear, the Applicant had requested several times earlier, for the IE to be rescheduled in 2017. It was the insurer who stalled in rescheduling the IE.[4]

[34] As I have found, these submissions are not supported by the evidence. It is inaccurate to state that the respondent failed to provide notice requesting an IE and proper reasons for its denial until January and February of 2018. It is also inaccurate to state that the insurer stalled in rescheduling the IE in relation to the disputed assessment. The applicant neglects to refer in his submissions to the

[3] Applicant's Written Submissions, page 5.
[4] Applicant's Written Submissions, page 6.

respondent's requests that he attend at more than one IE in the 21-month period between the submission of the plan and the respondent's final denial notice.

[35] The applicant's submissions are inaccurate in view of the evidence and, as I have determined, are ultimately unpersuasive. As a result, I have rejected his account of the respondent's handling of his claim. However, I am not satisfied that the applicant's submissions were made with the deliberate intent to mislead and deceive the Tribunal.

[36] When I view the applicant's submissions together with certain evidence he has tendered in this proceeding, though, his conduct rises to the threshold of vexatious and bad faith conduct warranting a costs award under Rule 19.

[37] The applicant tendered a November 8, 2017 email between his counsel and the adjuster as evidence the respondent stalled in rescheduling the IE. The applicant redacted the body of the email except for the following sentence: "That said, should you wish to reschedule same for our client to attend he is willing to attend."

[38] The unredacted version of this email, tendered by the respondent, shows that the applicant appropriately concealed details about settlement discussions. However, it also shows that the applicant concealed details indicating the correspondence was about an IE to determine his claim for an income replacement benefit, not the disputed Psychological Assessment. The email does not, therefore, support or even relate to the applicant's submission that he repeatedly tried to reschedule a Psychology IE. The redacted portions of the email also contradict the applicant's submission that the respondent was inactive in properly responding to his claim for nearly two years.

[39] In citing the November 8, 2017 email as proof that the applicant made repeated requests to reschedule a Psychology IE, the applicant has misrepresented the evidence.

[40] In addition, the treatment plan tendered by the applicant for a Psychological Assessment contains a pre-screen assessment report with information of questionable authenticity about the applicant and his injuries. I have already detailed my reasons for assigning no weight to the pre-screen assessment. In determining whether costs are warranted, I find on a balance of probabilities that aspects of the report have been falsely attributed to the applicant. I base this on the improbability that the applicant made remarks about the accident and his injuries to Dr. Aghamohseni that are identical to remarks attributed to a different insured person four years prior.

[41] The treatment plan bears the applicant's signature certifying that he reviewed the plan and that its contents are accurate and true. In tendering the pre-screen assessment as "compelling evidence" of his entitlement to the disputed assessment, the applicant again misrepresented evidence, frustrating the Tribunal's ability to fairly adjudicate the merits of his application. In my view, this amounts to vexatious and bad faith conduct.

[42] Misrepresenting evidence in a Tribunal proceeding is serious and should be strongly discouraged. It interferes with the Tribunal's ability to carry out a fair, efficient, and effective process in resolving disputes on their merits. The respondent was prejudiced by having to present evidence and argument to counter the applicant's inaccurate submissions and evidence, particularly as they related to its handling of his claims.

[43] While I am satisfied that the conduct of the applicant in this proceeding attracts an award of costs, I am not prepared to order the full amount requested by the respondent.

[44] Rule 19 requires me to consider the potential impact that ordering costs may have on individuals accessing the Tribunal system. Individuals seeking dispute resolution before the Tribunal often defer to the judgment of professionals in pursuing their claims, whether it be on what to advance as evidence in a Tribunal application or on the appropriate content of medical-legal reports. Ultimately, however, it is the parties who are liable to pay costs, and in this case, the burden falls on an individual applicant.

[45] A costs award must balance the need to discourage unreasonable, frivolous, vexatious or bad faith conduct in litigation against the real-world impact of costs penalties on those accessing the Tribunal system. On balance, considering all factors set out in Rule 19, I find an award in the amount of $100.00 to be appropriate in the circumstances.

CONCLUSION AND ORDER

[46] The applicant has failed to establish, on a balance of probabilities, that he is entitled to the benefits in dispute. There is no interest, and there is no award. The application is dismissed.

[47] The applicant is ordered to pay costs in the amount of $100.00 to the respondent.

Released: February 1, 2021

Theresa McGee
Vice-Chair