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Licence Appeal Tribunal

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Ontario

RECONSIDERATION DECISION

Before: Linda P. Lamoureux, Executive Chair

Date: September 22, 2017

Files: 16-000517/AABS

16-000663/AABS

Case Name: M.F.Z. v Aviva Insurance Canada

J.C.C. v Aviva Insurance Company of Canada

Written Submissions By:

For the Applicant: Philip Kai Kwong Yeung

For the Respondent: Petros Yannakis and Michelle Friedman

Overview

1. The applicants, Mr. Z and Ms. C, were involved in a motor vehicle accident on January 30, 2015. They applied for and received benefits under the *Statutory Accident Benefits Schedule – Effective September 1, 2010*[1] (the "*Schedule*") until their benefits were terminated by their insurer, Aviva Insurance Company ("Aviva"). The applicants then applied to the Licence Appeal Tribunal (the "Tribunal") regarding their entitlement to benefits.

2. On March 10, 2017, the Tribunal issued its final decisions in these matters. Both decisions involved the same determination at issue in this reconsideration: Aviva's responses and denials of certain treatment plans failed to comply with the notice requirements under s. 38(8) of the *Schedule* and, as a result, the consequences specified in s. 38(11) applied.

3. Based on these key findings, the Tribunal determined as follows:

    - Aviva was prohibited from ever taking the position that the applicants have a an impairment to which the Minor Injury Guideline ("MIG") applies, thus entitling them to treatment outside the Minor Injury monetary cap of $3,500;
    - The applicants were entitled to certain medical benefits totalling $2,569.08 for Mr. Z and $16.36 for Ms. C; and
    - Ms. C was entitled to $69.44 in prescription expenses found to be reasonable and necessary and related to the accident.

4. On April 12, 2017, Aviva requested a reconsideration of the Tribunal's decisions.[2]

5. The relevant criterion in this reconsideration is set out in Rule 18.2(b) of the Tribunal's *Rules of Practice and Procedure.* It states that the Executive Chair will not grant a request for reconsideration unless the Tribunal made a significant error of law or fact such that the Tribunal would likely have reached a different outcome.

[1] O. Reg. 34/10.
[2] On other issues in dispute, unrelated to the medical benefits associated with Aviva's non-compliance with s. 38(8), the Tribunal found in favour of Aviva. Those issues are not at issue in this reconsideration.

Decision

Ms. C

6. For the reasons that follow, I find that the Tribunal did not make an error with respect to its findings in Ms. C's matter and deny Aviva's request for reconsideration of Ms. C's decision.

Mr. Z

7. With respect to Mr. Z's reconsideration, I find that the Tribunal, although mostly correct in its findings, made an error with respect to the quantum of Mr. Z's entitlement. Mr. Z is not entitled to the entire balance of $2,569.08 as per the treatment plan dated August 31, 2015. Instead, Mr. Z is entitled to payment of $338.43 for the treatment sessions he attended between September 18, 2015 and the date he received Aviva's subsequent and compliant Explanation of Benefits ("EoB") dated October 2, 2015.

Reasons

8. For the sake of convenience, I will deal with both reconsideration requests together. In doing so, and for the following reasons, I grant Aviva's request for reconsideration of Mr. Z's decision in part and deny Aviva's request for reconsideration of Ms. C's decision.

A. The Tribunal's findings

Procedural requirements of ss. 38(8) and (9)

9. There are a number of provisions in the *Schedule* that are key to the Tribunal's original decisions in these matters and this reconsideration.

10. The first, s. 38(8), imposes multiple procedural requirements on an insurer after receiving a treatment (or assessment) plan: it must respond within 10 business days; state what benefits it will pay or not pay for; and, if it refuses to pay for any benefit, provide the medical and all other reasons why the insurer considers the treatment (or assessment) not to be reasonable or necessary.

11. The second, s. 38(9), adds another procedural requirement. If the insurer believes that the MIG applies, its notice under s. 38(8) "must so advise the insured person".

12. In these cases, the Tribunal found that Aviva did not comply with the procedural requirements outlined in ss. 38(8) and (9) after receiving the following requests for medical benefits from the applicants:

    - For Mr. Z: a treatment plan dated August 31, 2015 in the amount of $2,569.08 ("Mr. Z's treatment plan").
    - For Ms. C: a treatment plan dated May 14, 2015 for chiropractic services in the amount of $1,300 with a remaining balance of $16.36 ("Ms. C's treatment plan").

13. Specifically, the Tribunal found that Aviva did not provide medical and all other reasons why it considered Mr. Z's treatment plan not to be reasonable or necessary and was therefore non-compliant with s. 38(8). In addition, it found that Aviva did not comply with s. 38(9) in its response to the treatment plans noted above because it did not advise both applicants that the MIG applies.

Mandatory consequences of s. 38(11)

14. The Tribunal then found that Aviva's non-compliance under s. 38(8) triggered mandatory consequences under s. 38(11) that entitled the applicants to the treatment plans (or the balance thereof).

15. S. 38(11) sets out two consequences when an insurer fails to give notice in accordance with s. 38(8) after receiving a request for medical benefits.

16. First, the insurer is prohibited from taking the position that the insured person's impairment falls within the MIG, which limits recovery for medical and rehabilitation benefits to $3,500, as outlined in s. 18 of the *Schedule*.

17. Second, the insurer must pay for all goods and services described in the treatment plan that relate to a specific time period (starting on the 11th business day after the day the insurer received the treatment plan and ending on the day the insurer gives adequate notice).

18. The Tribunal found that both consequences of s. 38(11) apply to these matters.

B. Defective notices under ss. 38(8) and (9)

19. For the reasons set out below, I find that the Tribunal did not make a significant error in determining that Aviva failed to adequately respond to Mr. Z's and Ms. C's treatment plans.

20. There was sufficient evidence before the Tribunal to make the determination that Aviva failed to comply with the procedural requirements of s. 38(8) of the *Schedule*. S. 38(8) states as follows:

> (8) Within 10 business days after it receives the treatment and assessment plan, **the insurer shall give the insured person a notice that identifies the goods, services**, assessments and examinations described in the treatment and assessment plan that the insurer agrees to pay for, any **the insurer does not agree to pay for and the medical reasons and all of the other reasons why the insurer considers** any goods, services, assessments and examinations, or the proposed costs of **them, not to be reasonable and necessary** [emphasis mine].

21. Specifically, the Tribunal examined the EoB provided by Aviva to the applicants. An EoB is a statement sent to an insured from his or her insurer explaining what medical treatments and/or services will be paid or not paid.

22. On June 1, 2014, the *Schedule* was amended to introduce a requirement for insurers to provide "medical reasons and all of the other reasons" when denying medical and rehabilitation claims. One of the issues arising from the new language in s. 38(8) is whether a denial is incomplete and/or improper if "all" the other reasons are not listed.

23. The Tribunal was guided by *Augustin v. Unifund* ("*Augustin*")[3], which was the first case decided by the Financial Services Commission of Ontario ("FSCO") that interpreted "medical reasons" and, in so doing, determined that a denial letter that merely states an unsupported belief that a claimant's impairment may be a minor injury is inadequate.

[3] *Augustin v Unifund Insurance Company*, FSCO A12-000452, [2013] OFSCD No. 211 (QL).

Mr. Z's treatment plan

24. The Tribunal found that the denial of Mr. Z's treatment plan outlined in Aviva's EoB dated September 15 and 16, 2015 was unclear. It determined that the medical reason provided did not constitute any medical reason at all and, thus, Aviva's denial did not comply with the notice requirements in s. 38(8).

25. Specific to Mr. Z's treatment plan, the Tribunal stated at paragraph 75 as follows:

> While I cannot ascertain whether a response was provided within 10 days, the "medical reason" provided is so unclear – i.e. "The frequency of care does not generally diminish over time" – that it is meaningless. It is no reason at all. The requirement is to provide a medical reason, not leave the Applicant to guess what the reason is. The language is more than just an obvious grammatical error that might be considered a technical error under *Stranges*; rather it is so unclear as to not constitute any medical reason at all and thus violate the requirements of s. 38(8). Likewise, no mention is made of the MIG.

In my opinion, the Tribunal correctly determined that, in the circumstances of these matters, Aviva's denials did not meet the threshold for adequate medical reasons in its notices.

26. In addition, the Tribunal also found that Aviva did not comply with s. 38(9) because it did not mention the MIG. S. 38(9) states:

> If the insurer believes that the Minor Injury Guideline applies to the insured person's impairment, the notice under subsection (8) must so advise the insured person.

27. The Tribunal reviewed the EoBs dated September 15 and 16, 2015 responding to Mr. Z's treatment plan and found that "neither EoB stated that the Respondent believes that the injuries are minor and that the MIG applies"

Ms. C's treatment plan

28. Specific to Ms. C's treatment plan, the Tribunal stated:

> …I find that the Insurer's May 21, 2015 EoB regarding the first chiropractic plan does not comply with s. 38(9). The EoB merely

> references the $3,500 limit, but does not state that that the Insurer believes the MIG applies or directly mention the MIG. Enclosing portions of the Schedule concerning the MIG is not sufficient. S. 38(9) requires the Insurer to "advise the insured person" that it believes the MIG applies; this EoB does not do so…

Aviva's failure to comply

29. Based on the evidence available to the Tribunal, I agree that Aviva did not comply with ss. 38(8) and (9) when it responded to Mr. Z and Ms. C's requests for medical benefits and, as a result, Aviva's notices for not paying for the applicants' treatment plans were defective.[4]

30. Applying for medical benefits such as treatment, and responding to treatment requests, are common events in the life of an accident benefits claim. The legislation compels an insurer to communicate with its insured by providing sufficient information and notice when it does not agree to pay for treatment (or any other medical expenses).

31. Where an insurer refuses to pay a benefit that a person has applied for, or reduces the amount of a benefit that a person receives, the insurer is required to inform the person in writing of the procedure for resolving disputes relating to statutory accident benefits.[5] This is significant because the limitation period contained in s. 56 of the *Schedule* begins to run after the insurer properly refuses to pay an amount claimed.

32. Without sufficient notice, an insured cannot understand what the insurer is refusing to pay and why. He or she is in no position to agree or disagree with the insurer and cannot make an informed decision whether they should dispute the refusal.

33. In these cases, Aviva communicated its denials of the benefits in question through EoBs but the EoBs did not comply with requirements mandated by s. 38(8) or (9) of the *Schedule.* I do not find any error with respect to the Tribunal's findings and conclusions on the issue of defective notices. Aviva's notices were, in my view, clearly defective.

[4] For purposes of the s. 38(11) 2 and as discussed later in this decision, I find that Aviva subsequently cured its non-compliance with respect to Mr. Z's treatment plan as per its EoB dated October 2, 2015.
[5] *Smith v. Co-operators General Insurance Co.*, [2002] 2 SCR 129, 2002 SCC 30 (CanLII).

C. Consequences for defective notices under s. 38(11)

34. The consequences of a defective notice are spelled out in s. 38(11). Applying that section, the Tribunal prohibited Aviva from taking the position that the applicants' impairments fall within the MIG, and obligated Aviva to pay for the treatment plans until it gave the applicants proper notice.

35. Aviva disagrees with the Tribunal's interpretation and findings as they relate to s. 38(11). However, except for the issue of quantum of Mr. Z's treatment plan, I do not agree with Aviva for the following reasons.

Prohibition on taking MIG position under s. 38(11)1

36. The Tribunal found that s. 38(11)1 prohibits Aviva from ever taking the position that the applicants have a MIG impairment, thus potentially allowing for medical benefits above the $3,500 minor injury limit.

37. Aviva submits that the Tribunal made a significant error in determining that a deficient notice of denial of a treatment plan triggers a consequence under s. 38(11)1 that impacts an applicant's *entire* accident benefits claim. Instead, it argues, the consequence of s. 38(11)1 is specific to the treatment plan in question and cannot extend to an applicant's entire claim. I disagree.

38. S. 38(11)1 states:

> If the insurer fails to give a notice in accordance with subsection (8) in connection with a treatment and assessment plan, the following rules apply:
>
> 1. The insurer is prohibited from taking the position that the insured person has an **impairment** to which the Minor Injury Guideline applies (emphasis added).

39. The modern approach to statutory interpretation requires that the words of a statute be read "in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament."[6] This approach involves consideration of three factors: the language of the provision, the context in which the language is used, and the purpose of the legislation or statutory scheme in which the language is found.

[6] *Rizzo & Rizzo Shoes Ltd. (Re)*, [1998] 1 S.C.R. 27, 1998 CanLII 837 (SCC) citing *Driedger on the Construction of Statutes* (3rd ed. 1994) at page 87.

40. With this approach in mind, I find that the Tribunal correctly interpreted that Aviva's failure to follow the procedural requirements outlined in s. 38(8) resulted in Aviva being prohibited from raising the MIG in any future notices or responses to additional requests for medical benefits from the applicants.

41. On a plain reading of the *Schedule,* I note that the legislature opted to include the word impairment, not treatment, in laying out the prohibition. The language of the provision specifically states that if the insurer fails to give a notice in accordance with s. 38(8) in connection with a treatment plan, the insurer is prohibited from taking the position that the insured person has *an impairment* to which the MIG applies. In my opinion, the plain and ordinary meaning of the section means exactly what the Tribunal held. The word *impairment* denotes an individual's condition. It places no further restriction of the type that Aviva suggests.

42. The reference to the term "treatment and assessment plan" relates to the notice. The section requires an insurer to "give a notice in accordance with subsection (8) in connection with a treatment and assessment plan." The MIG prohibition that follows does not reference a particular treatment plan. In my opinion, the prohibition is not restricted to an insurer's response to a single treatment plan. It applies to the entire claim as stated by the Tribunal. Practically, I note that when an insurer makes a MIG determination, it does not apply to just one particular treatment plan; it applies to the entire claim.

43. I find that the Tribunal's findings are aligned with the modern approach to statutory interpretation taking into consideration not only the language of the provision, but also the context of accident benefits claims and the *Schedule*'s purpose with respect to the provision of an adequate notice.

44. The Tribunal was guided by several cases that support its interpretation that a failure to follow a procedural requirement in s. 38(8) results in the insurer being prohibited from raising the MIG limit on all treatment plans, not just a single one. These cases discuss the context of the language and the purpose of the legislation. For example, *Augustin* recognized that the requirement of "medical reasons" and the consequences of non-compliance outlined in s. 38(11)1 "makes insurers accountable for any initial decision that limits or denies initial treatment" and "prevents insurers from deciding to refuse treatment arbitrarily or on

principle." In *Ferawana* v. State Farm ("*Ferawana*")[7], another FSCO decision, the adjudicator recognized the significance of procedural non-compliance with s. 38(8) and the mandatory nature of the consequences of s. 38(11). I agree that these cases provided sound guiding principles on the relevant issues before the Tribunal.

45. Additionally, and turning to the *Schedule's* underlying purpose, Aviva's interpretation that a minor procedural non-compliance should not trigger the consequences of s. 38(11) is contrary to the consumer protection policy underlying the *Schedule*. I find that Aviva's position is also contrary to the very purpose of the legislature's goal to provide certainty around cost and payment for insurers and regulated health professionals.

46. Aviva relied on *Scarlett v. Belair ("Scarlett")*[8] in that it submitted that the Tribunal's reasoning directly contradicts *Scarlett*. I disagree. First, the circumstances and issues in *Scarlett* did not include defective notices and non-compliance with s. 38(8) of the *Schedule* such as in these cases. The issues in *Scarlett* were as follows: whether the $3,500 limit on med-rehab expenses in s. 18(1) was an exclusion of benefits that shifts the burden of proof to the insurer, the meaning of "compelling evidence", whether the MIG is binding, and whether the claimant suffered from a predominantly minor injury (and if this can be decided as a preliminary issue without a full hearing). Second, contrary to Aviva's suggestion that the Tribunal proclaimed automatic entitlement to medical benefits above the $3,500 minor injury cap, the Tribunal, in fact, denied other treatment plans in these matters because it found them not to be reasonable or necessary.

47. Aviva also submits that the Tribunal incorrectly deemed an otherwise temporary procedural non-compliance to grant substantive rights to enhanced medical benefits. I disagree because procedural non-compliance does not create substantive rights in these cases. A minor injury determination is not a benefit. It is a status, a category of impairment. It is not the only status or category of impairment within the *Schedule*. A determination that one is catastrophic is also a status and a category of impairment that may result in enhanced benefits. While it is true that achieving a certain impairment status may result in access to more benefits, entitlement to these benefits will depend on meeting the requirements outlined in the *Schedule*.

[7] *Ferawana v. State Farm Mutual Automobile Insurance Co.*, FSCO No. A13-005419, [2016] O.F.S.C.D. No 247 (QL).
[8] *Scarlett v. Belair Insurance*, 2015 ONSC 3635 (CanLII).

48. Significantly, s. 38(11)1 does not prohibit Aviva from denying future treatment plans requested by the applicants. It only prohibits Aviva from denying future treatment based on a MIG impairment. Aviva is not prohibited from denying any future benefits on the basis that they are not reasonable or necessary. In my opinion, this is a fair interpretation to Aviva and the applicants.

49. Therefore, I find that the Tribunal did not make a significant error in its finding that in accordance with s. 38(11)1, Aviva is prohibited from taking the position that the applicants have a MIG impairment. To decide otherwise would have been contrary to the purpose of the *Schedule*.

"Shall pay" provision under s. 38(11)2

50. Aviva also submits that the Tribunal erred in its interpretation of s. 38(11)2 by deeming the treatment plans and expenses associated with the defective notice payable automatically without adjudicating whether the treatment is "reasonable and necessary".

51. I find that there was no significant error with respect to the Tribunal's finding that the respondent's procedural non-compliance with s. 38(8) renders the treatment plans outlined above payable in accordance with the "shall pay" provision of s. 38(11)2. However, I do find that the Tribunal made an error with respect to the quantum payable for Mr. Z's treatment plan and that $2,569.08 is an incorrect amount because Aviva cured its initial and deficient response to Mr. Z's treatment plan.

52. S. 38(11)2 states:

> **If the insurer fails to give a notice** in accordance with subsection (8) in connection with a treatment and assessment plan, the following rules apply:
>
> > 2. The 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) (emphasis added).

I find that s. 38(11)2 is a mandatory provision, as denoted by the legislature's choice of the word "shall". Although it gives an insurer a window to "cure" a

defective notice, without such a cure it renders any goods, services, and assessments and examinations in the treatment plan payable.

Ms. C's defective notice not cured

53. The Tribunal considered whether the defective notices were cured and found that they were not. I agree with the Tribunal that the defective notice of Ms. C's treatment plan was not cured and that, as a result, Aviva is required to pay for the balance of Ms. C's treatment plan and prescription medication expenses (that are reasonable and necessary). There is no evidence to the contrary and I accept this finding.

Mr. Z's defective notice cured and Aviva's obligation to pay limited

54. However, in the case of Mr. Z's treatment plan, I find that Aviva's defective notice was cured when Aviva sent another notice on October 2, 2015 and that this compliant notice limited Aviva's obligation to pay for Mr. Z's treatment plan.

55. The Tribunal should have assessed the relevant time period under s. 38(11)2. Specifically, from September 18, 2015, (the 11th business day after Aviva received Mr. Z's treatment plan) and the date the EoB dated October 2, 2015 was received. Adding 5 days to ensure its receipt, that date is October 7, 2015. Aviva's obligation to pay for services related to Mr. Z's treatment plan should have been limited to the treatment that took place between September 18, 2015 and October 7, 2015.

56. Instead, the Tribunal stated, "I have nothing before me to indicate the Respondent ever provided a compliant notice. Thus, the chiropractic treatment plan is approved." I find that there was evidence before the Tribunal that indicated Aviva sent notice in compliance with s. 38(8) on October 2, 2015[9] thereby curing its previous deficient notices dated September 15 and 16, 2015. This EoB denied Mr. Z's entitlement to chiropractic treatment based on medical reasons and provided the report of an Insurer Examination that assessed whether the treatment plan was reasonable and necessary. The Tribunal should have considered the impact of this compliant EoB in limiting Aviva's obligation to pay in accordance with s. 38(11)2.

[9] EoB dated October 2, 2015 in Applicant's factum at Tab 17.

57. Aviva submits that the Tribunal failed to consider evidence of sign-in sheets from Mr. Z's service provider that showed limited attendances for treatment during the relevant time period outlined above. This is true. The Tribunal had evidence before it that Mr. Z only attended treatment sessions on September 22, 2015, October 3 and October 6, 2015.[10] Aviva's obligations to pay should have been limited to no more than the treatment sessions attended between September 18, 2015 and October 7, 2015, at the rate of $112.81 per treatment session.[11] Therefore, the Tribunal erred in its finding under s. 38(11)2 but only with respect to the quantum. The correct amount payable to Mr. Z is $338.43, the total of three treatment sessions at the rate of $112.81 per session.

D. S. 38(11)2 and the "reasonable and necessary" test in s. 15

58. Aviva submits that the Tribunal erred by focusing on the consequences of s. 38(11)2 and neglecting to adjudicate the applicant's entitlement to the treatment plans at issue. Aviva argued that it is only obliged to pay for treatment incurred if it is determined to be reasonable and necessary, regardless of whether the "shall pay" provision of s. 38(11)2 applies. To hold otherwise, it submitted, would fly in the face of the Court of Appeal's decision in *Stranges v Allstate ("Stranges")*[12] as well as the arbitration decision of *Martinez v. Aviva ("Martinez")*[13]. I disagree for the following reasons.

59. The term "reasonable and necessary" outlined in s. 15 is omitted from s. 38(11)2. While s. 15 requires that an Insurer "shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident", s. 38(11)2 omits "reasonable and necessary" and "expenses incurred". Instead, s. 38(11)2 states that the "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)" (emphasis mine). In my opinion, the language in s. 38(11)2 supports the Tribunal's adjudication of the treatment plans in question. In these matters, an analysis under s. 15 is not required.

[10] Sign in sheet from Perfect Physio in Applicant's Factum at Tab 18.
[11] Aviva accepts the rate of $112.81 per treatment session, at paragraph 10 of Aviva's request for reconsideration of Mr. Z's decision.
[12] *Stranges v. Allstate Insurance Company of Canada*, 2010 ONCA 457 (CanLII) [leave to appeal to the Supreme Court of Canada denied].
[13] *Martinez v. Aviva Canada Inc*, FSCO No. A14-009657, [2017] O.F.S.C.D. No. 33 (QL).

60. I also find that the reasoning in *Stranges* is not applicable in these cases and easily distinguishable. *Stranges* dealt with the issue of whether a defective refusal from an insurer would automatically obligate an insurer to pay ongoing weekly benefits. In *Stranges*, the Court held that an inadequate refusal notice from an insurer did not automatically entitle the insured person to payment of income replacement benefits (IRBs) in perpetuity. *Stranges* determined that to succeed on her claim, Ms. Stranges was still required to prove that she met the IRB disability test. Significantly, the refusal of an insurer to pay ongoing weekly benefits cannot be equated with a refusal to pay medical benefits. *Stranges* does not address the effect of an insurer's failure to deliver notice under ss. 38(8) and (9). Nor does it consider the MIG or an insurer's obligation under s. 38(11)2 to pay a medical professional for a particular treatment that is incurred.

61. *Martinez* is also distinguishable from the cases at hand since it did not involve the issue of a non-compliant notice. Rather, *Martinez* concerned an applicant's onus to prove entitlement to a treatment plan instead of being deemed automatically qualified to receive the remaining balance of the $3,500 Minor Injury cap. This is not the issue in this reconsideration.

62. The Tribunal was guided by *Ferawana*[14], a FSCO arbitration decision that is more on point with the circumstances of these matters. In *Ferawana*, the insurer did not follow the procedural requirements in s. 38(8) and argued that a minor procedural non-compliance with s. 38(11)2 does not automatically entitle an applicant to the disputed benefit because the applicant still has to show that the request was reasonable and necessary. The adjudicator rejected this argument and stated

> If correct, it would render the mandatory requirements of subsection (11) meaningless. The payment regime is mandatory and I have no jurisdiction to carve out exceptions. Consequently, there is no need for me to proceed with an analysis of whether Mr. Ferawana's claim …was reasonable and necessary.

I agree and find that *Ferawana* is consistent with the purpose of the *Schedule.* The same approach was recognized in *R.H. and TD Insurance Meloche Monnex*.[15]

[14] See footnote 7.
[15] *16-000634 v TD Insurance Meloche Monnex*, 2017 CanLII 1555 (ON LAT).

63. The Tribunal correctly found that Aviva could not ignore treatment plans, provide inadequate notice of its refusal to pay for the treatment or change its mind after the applicants had incurred the cost. Such an interpretation would be contrary to the consumer-focused policy underlying the *Schedule*. If an insurer fails to give notice in accordance with the *Schedule*, an insured person should be able to rely on s. 38(11)2 and proceed to obtain the treatment that was recommended by medical practitioners with confidence that the insurer will have to pay for same. The insurer should not later be able to challenge the reasonableness of the insured person having incurred that expense. To hold otherwise, would deprive s. 38(11)2 of any purpose.

64. Once the Tribunal determined that the treatment plans and expenses in question were due on the basis of non-compliance with s. 38(8), which then triggered the consequences of s. 38(11)2, it was no longer required to adjudicate whether they were reasonable and necessary.

65. This does not mean, however, that *all* treatment plans are automatically approved or payable. Any future treatment plans advanced by these applicants are still subject to the requirements of the *Schedule*, such as the test set out at s. 15 that medical benefits be reasonable and necessary.

66. In these cases, the Tribunal correctly applied the *Schedule* and determined that Aviva is required to pay for the balance of the treatment and expenses for which it supplied a defective notice that did not comply with the *Schedule* (except for the limited obligation for Mr. Z's treatment plan as noted above).

Conclusion

67. Therefore, I deny Aviva's request for reconsideration for the Tribunal's decision with respect to Ms. C's claims.

68. With respect to Mr. Z's reconsideration, I agree with Aviva's request only as it relates to quantum in that Mr. Z is not entitled to $2,569.08 as stated in the Tribunal's decision. Instead, Mr. Z is entitled to a medical benefit for the three treatment sessions he attended between September 18, 2015 and the date Aviva's compliant EoB dated October 2, 2015 was received, in the amount of $338.43.

Linda P. Lamoureux
Executive Chair
Safety, Licensing Appeals and Standards Tribunals Ontario

Released: September 22, 2017