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Ontario



**Date: 2017-06-22**
**Tribunal File Number: 16-001810/AABS**
**Case Name: 16-001810 v Aviva Insurance**

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:

**Y. D.**

**Applicant**

and

**Aviva Insurance**

**Respondent**

## DECISION

**ADJUDICATOR:** **Cezary Paluch**

**APPEARANCES:**

**Counsel for the Applicant:** **Jasmine Daya**

**Counsel for the Respondent:** **Shivani Mehta**
**Kimberely Tye**

**Representative for the Respondent:** **Jennifer McDonald, Claims Adjuster**

**Court Reporter:** **Jovana Velimirovic**

**Heard In-Person:** **April 11, 2017**

## REASONS FOR DECISION AND ORDER

## OVERVIEW:

1. The applicant, YD, was a victim of a motor vehicle accident that occurred on December 23, 2015. She claimed statutory benefits from the respondent Aviva Insurance ("Aviva") under the *Statutory Accident Benefits Schedule* – Effective after September 1, 2010 (the "Schedule")[1]. A dispute arose regarding her entitlement to attendant care benefits ("ACBs") and for payment of a cost of examination.

2. The applicant takes the position that the ACBs are eligible for coverage because they were properly "incurred" as the service provider was an accredited medical physician, the applicant's husband, SD.

3. In the alternative, the applicant argues that Aviva should be estopped from taking the position that the ACBs were not "incurred" as Aviva initially paid the benefits from December 23, 2015 until May 22, 2016. Simply put, the applicant says, it would be inequitable or in bad faith to permit Aviva to change their opinion that SD no longer fit in within the accepted class of service providers.

4. In response, Aviva submits that the ACBs are not eligible for coverage because they were not "incurred". Aviva essentially advances two main arguments in support of its position. First, that there was no legal obligation between the applicant and the service provider to pay for the service rendered. Second, SD's services did not fit within either class of attendant care providers that the legislation requires.

5. With respect to the estoppel argument, the respondent has not raised any jurisdictional objection but relied on the position that the applicant has failed to establish that she suffered any detriment and does not meet the three-part test.

6. One significant point in this case is that the respondent has acknowledged that the initial adjuster on the file incorrectly handled the applicant's file by misinterpreting s.3(7)(e) of the Schedule and agreeing to fund the monthly ACBs which were paid from December 23, 2015, until May 22, 2016. Several months later, upon further review of the file, the respondent, changed its position and held that the submitted expenses did not meet the definition of an incurred expenses in s. 3(7)(e) of the Schedule.

7. A hearing was held on April 11, 2017, consisting of written submissions and oral evidence to consider the applicant's application pursuant to s. 280(2) of the *Insurance Act*, R.S.O. 1990, and c. I-8 (the "Act").

8. The applicant did not attend the in-person portion of the hearing.

[1] The Statutory Accident Benefits Schedule – Effective September 1, 2010, Ontario Regulation 34/10, as amended.

**ISSUES IN DISPUTE:**

9. The questions raised by this appeal are the following:

   i. Is the applicant entitled to attendant care benefits in the amount of $6,000.00 per month for the period May 23, 2016 to July 27, 2016?

   ii. Is the applicant entitled to attendant care benefits in the amount of $1,797.00 per month for the period July 28, 2016 to December 31, 2016?[2]

   iii. Is the applicant entitled to the cost of examination in the amount of $1,971.78, treatment plan dated June 27, 2016, recommended by Synoptic Medical Assessments Inc. for in-home assessment and attendant care needs?

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

   v. Can the License Appeal Tribunal ("LAT") use an equitable remedy such as estoppel by convention to prevent the enforcement of provisions in a statute in appropriate circumstances?

**RESULT:**

10. For reasons that will be explained below, I conclude that the applicant is not entitled to attendant care benefits claimed because she has not proven on a balance of probabilities that she incurred the expenses for this benefit as required by the Schedule.

11. I also do not find that the cost of examination for an attendant care assessment is reasonable and necessary.

12. I also find that the equitable remedy requested by the applicant lies beyond the scope or authority of the LAT to award.

13. Having made this decision, the appeal on interest must be dismissed.

**FACTS:**

14. I will provide a brief outline of the facts at this point and expand upon the facts as is necessary in my analysis.

15. The Schedule authorizes ACBs to pay for reasonable and necessary expenses incurred to hire someone to help with self-care activities that an insured person is

[2] This date was amended on consent at the in-person hearing. In addition, whether the applicant sustained an impairment that was not a "minor injury" within the meaning of the Schedule as a result of the accident was also not contested at the hearing.

unable to perform as a result of their accident related injuries. Such activities are understood to include bathing, grooming, dressing, feeding, ambulating, supervisory care and toileting.

16. The amount of a monthly ACBs is determined in accordance with a worksheet mandated by statute used to calculate the services being a Form 1 - Assessment of Attendant Care Needs ("Form 1"). There are three categories of care, levels 1, 2 and 3. Level 1 is for routine personal care and Level 3 is for more complex health care.

17. On December 30, 2015, Ashok Jain, an occupational therapist, assessed YD's attendant care needs and completed the Form 1 and concluded that the applicant would require considerable aid with her personal care activities including 722.4 hours of assistance payable at $9,081.36 per month.

18. The applicant chose to have attendant care provided by a family member, her husband, SD, who happened to be a medical doctor rather than a traditional third party arm's-length service provider.

19. On January 8, 2016, in response to the Form 1, Aviva began to pay the ACBs in the amount of $3,000.00 as this would be the normal policy limits for someone who sustained non-catastrophic injuries.

20. On April 14, 2016, with respect to receipt of an Expenses Claim Form (OCF-6) dated March 21, 2016, from the applicant, Aviva requested proof of economic loss sustained by SD by requesting employment information or pay stubs before or during the period the attendant care services were completed.

21. It stands to reason that Aviva would request this information as the Schedule was changed in 2010 to require proof of economic loss after previously not requiring an applicant to show that the attendant care provider sustained an economic loss. In *Henry v. Gore Mutual Insurance Company*, Justice Ray commented that the intent of this change was to: "prevent a member of an insured's family who was not ordinarily an income earner or working outside the home, from profiting from an attendant care benefit, when they would likely be at home anyway - and would have looked after the injured insured without compensation."[3]

22. On April 19, 2016, Aviva stated that the initial explanation of benefits letter contained a mistake and the proper amount of the benefits under YD's policy was $6,000.00 (not $3,000.00) as she had purchased the optional coverage. Therefore, while the Form 1 amount was $9,081.31 per month, the maximum benefit payable under the Schedule was $6,000.00 per month.

[3] *Henry v. Gore Mutual Insurance Company*, 2012 ONSC 3687 (CanLII) at paragraph 7.

23. On June 14, 2016, after an Insurer's Examination, a new Form 1 was completed by Harush Sharma, occupational therapist, who concluded that YD no longer required an aide to complete her personal care duties and the monthly ACBs were calculated as $0.00. ACB's would not be paid for any incurred expenses past June 30, 2016.

24. On July 27, 2016, Lani Legaspi, an occupational therapist, hired by the applicant, completed another updated Form 1, and concluded that YD demonstrated insufficient physical tolerances to complete self-care tasks independently and recommended that she receive attendant care assistance calculated at $1,797.02 per month.

25. On August 4, 2016, the applicant filed her application to the Tribunal for dispute resolution as required by the *Insurance Act*.

26. As stated above, the main claim in the matter was one for statutory accident benefits in relation to attendant care.

**APPLICATION OF LAW TO FACTS:**

**Attendant Care Benefits - Is the applicant entitled to an attendant care benefit?**

27. A requirement for entitlement is that the expense is incurred. Section 3(7)(e) of the Schedule sets out the definition of "incurred" that is relevant in this appeal and states that an expense is not incurred unless:

> (i) the insured person has received the goods or services to which the expenses relates,
>
> (ii) the insured person has paid the expense, has promised to pay the expense or is otherwise legally obligated to pay the expense, and
>
> (iii) the person who provided the goods or services,
>
> (A) did so in the course of the employment, occupation or profession in which he or she would ordinarily have been engaged, but for the accident, or
>
> (B) sustained an economic loss as a result of providing the goods or services to the insured person

28. Therefore, my reading of "incurred" in the Schedule, s. 3(7)(e) sets out three (3) requirements for ACBs to be payable to the claimant which I discuss below. All three have to be met for the applicant to succeed.

**1st Requirement – Received services to which expenses relate**

29. During a period of approximately 9 months, the applicant submitted several "*Expenses Claim Forms* (OCF-6)" "(the "OCF-6 Form")"[4] attached to a second document labelled an "*Attendant Care Expense Form*"[5] (the "ACE Form") that specified SD's services and hours in providing care to his wife. These two forms provide the following helpful information:

i. *For the period May 23, 2016 to July 22, 2016* – This OCF-6 Form was signed by the applicant on July 29, 2016. It totals $18,162.72 ($9,081.35 per month) for 727.60 hours of service each month. This amounts to virtually 24 hour care a day at $12.48 per hour. On the OCF-6 Form, under the column and heading "*Description of Goods and Services and Name of Service Provider*" was hand written "Attendant Care" but the name of the service provider was not included. The OCF-6 Form also required the claimant to: "*Please attach **all** bills and receipts*." Attached to the OCF-6 Form was the ACE Form signed by SD and dated June 22, 2016, and another ACE Form dated on July 22, 2016. Notably, both of these two ACE Forms had exactly the same categories and hours of service provided despite being for two separate time periods. The ACE Forms indicated that SD provided the following attendant care services to the applicant: dressing, undressing, grooming, feeding, mobility, exercise, skin care, medication, hygiene, basic supervisory care.

ii. *For the period from September 23, 2016 to October 22, 2016* – This OCF-6 Form was signed by the applicant on November 4, 2016 and totals $9,081.36. Again, the name the name of the service provider was not included in the appropriate column. The OCF-6 Form requires the applicant to attach **all** bills and receipts but none appeared to me to be attached except for the ACE Form. This ACE Form was signed by SD and dated October 22, 2016. In cross examination, SD conceded that he did not complete this form but only signed it.

30. The applicant submits that her husband, SD, provided care services to her from December 23, 2015 to December 31 2016 (albeit at different levels of care throughout this time). In her Affidavit sworn March 24, 2017, at paragraph 7 and 8, the applicant stated: "I required assistance to perform my activities of daily living, such as bathing, dressing, grooming and nail care. While I have now resumed many but not all of my self-care activities, it is with increased time and effort due to pain and fatigue. My husband, SD, provided care for me."

[4] This is an approved auto insurance claim form approved by the Superintendent of the Financial Services Commission of Ontario (FSCO).

[5] This form does not appear to be an approved FSCO form.

31. At the oral hearing, SD testified that he provided the attendant care to YD and was "*constantly at her beck and call*" especially during the acute phase of her injury. He conceded that the applicant's son also provided care to her from time to time but it was SD who was the primary caregiver and there was no other person hired to provide attendant care. SD reviewed the list of the specific tasks that the occupational therapist set out in the initial Form 1 and confirmed that he provided this type of care to the applicant. Similarly, with respect to the second Form 1 of July 27, 2016, prepared by Lani Legaspi, SD stated that he started to provide reduced care at the rate of $1,792.01 per month. SD also testified that his wife gradually made progress in terms of her self-care and became totally independent by the end of 2016.

32. When asked about the ACE Form that he signed and whether it was a standard form, SD responded: "*That I provided, yes*." When asked whether in October 2016, in fact, he provided 426 hours of supervisory care, he replied: "*Probably*". When asked whether he provided $9,000.00 in attendant care services in the month of September to October, he said: "*I don't know how to quantify the amount of time. It may have been more or less. I don't know. The form that I filled out was just a standard form that I did from month to month*." Later in his testimony with respect to the time allocated on the ACE Form regarding the services he provided, he said: "*The amount of time I can't quantify*."

33. When asked in re-examination by the applicant's lawyer, whether there was any way to actually measure how much time he was providing attendant care to his wife, SD, explained that it was actually impossible to measure. He said: "*Without having a timer there, clocking in and out, it is impossible."*

34. Although it appeared to me that that SD provided valuable and much needed attendant care services to YD, I find the evidence presented does not support a finding that SD was providing attendant care services for the entire period claimed from December 23, 2015 to December 31, 2016 in accordance with the corresponding expense claim forms (or for that matter in accordance with the corresponding Form 1s).

***Discrepancies and insufficient evidence***

35. My decision turns on several key discrepancies in the evidence regarding the services claimed by the applicant versus the actual services provided by SD (at least from July 2016 onwards), and also the absence of key information with respect to material issues required to be proven. Indeed, the evidentiary record suggests that:

i. SD acknowledged in his own evidence that as of July 2016 the applicant required lesser amount of care being $1,797.00 per month (as indicated on the updated Form 1 by Ms. Legaspi), yet he still submitted an expense claim form for the full amount of $9,081.00 (as indicated on the OCF-6 Form that covered the period September 23, 2016 to October 22, 2016).

ii. In the period of September/October 2016, SD, claimed 4.3 hours for Coordination of Attendant Care. Again, in his oral testimony, he said that he lived in the same house as the applicant and was at her beck and call. I did not understand why 4.3 hours per week was needed for the applicant to co-ordinate the attendant care with her husband who was living with her. This was not a case where a third-party service provider had to travel to the applicant's home and fit the required care into their schedule.

iii. SD also conceded that he no longer provided services such as grooming, undressing, dressing, shampooing the applicant's hair despite the admission in his oral testimony that he was still submitting expense claim forms indicating that those services were being provided.

iv. SD could not state who wrote the itemized details of services and time allocation on the ACE Forms that the applicant submitted to Aviva and could not explain how the services and hours were quantified or calculated. The discrepancies between the ACE Forms and what the actual attendant care needs were remained difficult to reconcile. This was critical information, especially on a going forward basis, as once entitlement is determined, the amount of the benefit is based on the insured's need for care which undoubtedly would fluctuate.

v. YD's affidavit unfortunately was very brief and did not specify in any detail what specific services SD provided to her other than stating in a very general way that that SD provided care to her. These factual details are important to the determination of this issue. It informs whether the services provide correspond with the expense claim forms that were submitted to the insurer.

vi. SD did not provide any time dockets, or daily logs, or job diaries, of the dates and times that the itemized services or activities were performed. Again, this factual detail was critical as it would have assisted me in determining how the hours set out in the submitted Attendant Care Expense Forms were recorded and calculated. This was especially key in this case as the submitted Expense Claims Forms covering different periods of time had exactly the same hours. It appeared to me that SD was simply signing a standard form from month to month, or copying from the first initial form (based on the Form 1), and this was not an accurate way to capture the actual services that he provided. The reasonable inference to me from all the documentation and evidence was that the submitted Expense Claims Forms were not be completely reliable or accurate as they were not tracked or verified by the actual service provider - SD. This tracking was even more pertinent in this matter as SD admitted in his testimony that he had difficulty quantifying the time he spent on providing the services.

vii. I also do not accept that it was impossible for SD in his capacity as the service provider, to measure how much time he devoted to his attendant care tasks. The timer was not the only option. As an experienced medical doctor, I would have expected SD to be meticulous in his daily record keeping of his interaction with patients or clients. For example, a hand written daily service record could have been used or perhaps a computer-generated spreadsheet. Whether it was a conscious decision, or an innocent oversight on the part of SD is not relevant. In my view, such records are the type that would be required in order to deal with any disputes arising during the course of receiving any benefits from an insurance company.

viii. It seems to me, that SD, as the service provider, did not provide any actual invoices, or bills, or similar type documents to the applicant. While the applicant has provided a Form 1, an Expense Claim Form (OCF-6), and another form(s) labelled an "Attendant Care Expense Form" (the ACE Form), she would also need to provide me with an actual invoice or a bill or a receipt from the service provider, or some similar document, to substantiate that the expenses have been incurred. I did not receive any such documentation at the time of the hearing from the applicant. The ACE Forms that were provided fall short of that. They do not have the typical indicia of being an invoice or bill. That is, detailed account of the services to a client and date when they were provided, terms of payment due date for payment. An invoice or bill should clearly be labelled as such at the top of the document. One sends an invoice to someone because they owe you money. The submitted ACE Forms, on their face, do not appear to me to be actual invoices or a demands for payment.

ix. I am struck by the disconnect that the Form 1 of May 30, 2016 prepared by Harish Sharma (on behalf of the respondent) that recommended $0.00 in monthly ACBs, to the Form 1 of July 27, 2016 prepared by Lani Legaspi (on behalf of the applicant) (notably 2 months later when YD's self-care were improving) that recommended ACBs at $1,797.02. Certainly, they cannot be both right in terms of representing an accurate assessment of SD's attendant care needs.

36. The legislative history of the Schedule makes it clear that the amendments were designed to provide a system of checks and balances on attendant care. The attendant care benefit is intended to reimburse an insured person for money expanded to a professional attendant care provider.

37. Based upon the analysis above, and the evidence taken as a whole, I find that the services allegedly performed by SD were not proven. In the alternative, if part of these alleged services were performed, they were not performed to the extent or at the cost alleged in the various claims.

38. Therefore, the first requirement of s. 3(7)(e)(i) of the Schedule that the insured person received the goods or services to which the expenses relate has not been met.

**2nd Requirement – Legal Obligation**

39. Section 3(7)(3)(ii) requires that the insured person has paid the expense, has promised to pay the expense or is otherwise legally obligated to pay the expense. Thus, there must be a legal obligation between the applicant and the service provider to pay for the services rendered. In this case, the legal obligation would have to be between the applicant wife, YD, and her husband, SD.

40. The term "legal obligation" is not defined in the Schedule. The Black's Law Dictionary defines "obligation" as "*that which a person is bound to do…; any duty imposed by law, promise, contract…an undertaking to perform*."[6] Likewise, in *Terranova and Economical Insurance* Arbitrator Mongeon states that the legal obligation typically pre-supposes some sort of contract. [7]

41. Here, the evidence demonstrates that all that has been submitted by the applicant are the expense claim forms. No other evidence was ever submitted to indicate a contractual arrangement or legal obligation. In SD's oral testimony, he confirmed that his wife had not paid him anything, or even more significantly, that he did not have any expectation of payment from her. Again, this was consistent with the overall evidence and supported my finding that no formal invoice or bill was ever provided by SD to YD. More to the point, there was no demand for payment, no contract for services, no expectation of payment and no legal obligation.

42. Where an insured person does not have to legally pay someone there is nothing to reimburse the insured person for. Therefore, I find that there was no legal obligation for the applicant to pay SD for his services and this part of the test was also not satisfied.

**3rd Requirement – 2 classes of service providers**

43. A final requirement for ACBs to be "incurred", and therefore payable, is that section 3(7)(e)(iii) provides for two classes of attendant care providers:

A. The professional providers who are typically, though not necessarily, at arms-length from the applicant; and,

B. The applicant's family or friend who sustain an economic loss as a result of providing the service.

[6] *Black's Law Dictionary*, 6th Ed. West Publishing Co., page 1074.
[7] *Terranova and Economical Mutual Insurance Company*, FSCO A15-001653, April 1, 2016, paragraph 11.

44. The applicant's husband stands at the cross roads of these two classes of service providers. He was a family member of the applicant who was also professionally qualified to provide the requisite attendant care services by virtue of his medical profession.



**(A) Professional Class - In the course of the employment, occupation or profession**

45. According to the applicant's affidavit, her husband SD provided care for her given his abilities as a medical doctor and that she preferred his assistance over an outsider with lesser abilities and qualifications.

46. In support of his qualifications, the applicant's representative submitted into evidence SD's 64-page curriculum vitae[8] as of 2007 outlining his formal medical education, clinical training, academic and hospital appointments, employment and publications. SD testified that as a medical physician the essence of what he did was all aspects of patient care. The evidentiary record also suggests that:

i. SD was a physician for over 30 years with a speciality in obstetrics and gynaecology including a sub-speciality in reproductive endocrinology and infertility. He looked after men and women who could not conceive.

ii. At the time of the accident, SD was on a leave of absence from his regular work as a specialist at the Newlife Fertility Centre and was preparing research for a book and also doing ultrasound dictations for OHIP.

iii. SD stopped working at the Newlife Fertility Centre at the end of January 2015, and was not seeing patients or providing patient care at the time of the accident in December 2015. He returned to Newlife Fertility Centre sometime in August 2016.

iv. At the time of the accident or just prior to the accident SD was not engaged in such services as: dressing/undressing, shampooing a patient's care, clipping nails, washing face, blow drying hair.

47. Applying a broad interpretation to the legislative provisions in question and accepting that the goal of the legislation is to reduce hardship on accident victims, I am still unable to conclude that the applicant's husband's services fits within the meaning and intent of s. 3(7)(e)(iii)(A). This determination is made after considering carefully all of the evidence including the oral evidence of SD. The legislative provision requires that the service is the product of an employment, occupation, or profession in which the

[8] Exhibit# 1.

applicant's husband would have normally been engaged even if his wife was not involved in a motor vehicle accident.

48. My decision turns on the need for the applicant's husband to "ordinarily have been engaged" in providing her service "but for the accident". In other words, the test is whether SD was providing services to his wife in the same manner as he was providing in his normal employment (not whether SD was qualified to provide the care). It was clear during his testimony that SD's regular employment (working at Newlife Fertility Centre as a fertility specialist) he would not be involved in several of the tasks that were listed on the Form 1 (namely, hair washing, grooming, dress/undress, hygiene, bathing, exercise, prepare and feeding meals, assist in walking, get in and out of wheelchair). He was a specialist who was assisting people with fertility difficulties. The duties and tasks of that job, particularly, gynecologist and reproductive infertility specialist, was not a professional that predominantly provides for the activities and the three levels of care specified in the Form 1: routine personal care, basic supervisor functions, and complex health/care and hygiene functions.

49. Having considered all of evidence, and compared the activities and tasks on the Form 1s and job duties of the service provider, I conclude that SD's normal employment or profession was not the same as caring for his wife. Any other conclusion would ignore the mandatory language of the section 3(7)(e)(i) that the service provider be ordinarily engaged in providing such services during his or her profession or employment but for the accident.

**(B) Personal Class - Sustained an economic loss**

50. The applicant is entitled to an attendant care benefit under this provision if she can show that her husband sustained an economic loss in providing her service. If no such loss is sustained, no ACBs are payable in respect of care provided by a family member, even if the family member provided the care in the course of employment, occupation or profession.

51. In response to the Court of Appeal for Ontario's decision in *Henry v. Gore Mutual Insurance Co*.[9], amendments in Ontario Regulation 347/13 came into effect on February 1, 2014. Applicable to this case is that s. 19(3) of the Schedule was amended to limit the benefit payable to a family member to the amount of economic loss sustained by the family member. Therefore, if an applicant's service provider takes the position that they sustained an economic loss, this section limits the amount of the ACBs payable to the actual economic loss sustained. Again, there was no evidence adduced to quantify or identify with any certainty any economic loss on a pecuniary or monetary basis.

52. At first, I have no difficulty in concluding that the applicant's husband falls within this class. He is a family member who took time to care for his ailing wife and he

[9] *Henry v. Gore Mutual Insurance Co.*, 2013 ONCA 480 (CanLII).

happens to have professional qualification for the services he provided. However, s. 3(7)(e)(iii)(B) goes further and requires that the applicant show that her husband sustained an economic loss as a result of providing her service.

53. Keeping in mind that "economic loss" solely remains a factual determination – "a rough check", and not a means of calculating the actual loss that is required, this evidence was still very vague and the allegations of loss were not quantified or corroborated with any supporting documentation (i.e. I have not been provided with any particulars as to when SD's book may be published, if there were any deadlines or payment advances or lost wages that were missed as a result of any delay in writing the book). I do not find that oral testimony of SD alone was sufficient to establish economic loss and the required threshold finding for "incurred expense" was not met.

54. It was also clear to me that SD did not have to sacrifice his work at the fertility clinic in order to care for his wife as he was not working at the clinic at the time of the accident. SD only returned to the clinic in August 2016 (when YD was already discharged from the fracture clinic and well on her way to a full recovery). Albeit, no pay stubs or records of employment were ever provided to substantiate if SD had to sacrifice any employment opportunities at the clinic to care for his wife. Furthermore, at the date of the accident, SD was not seeing any patients and was not involved in any patient care or performing any of the duties as outlined on the Forms 1 as part of his professions or employment.

55. In my opinion, there was insufficient evidence of such economic loss particularly that economic loss should be restricted to monetary or financial loss and not to some expanded or broader definition that encompasses loss of profits or loss of time or loss of opportunity. The onus was on the applicant to demonstrate an economic loss to date. She has not done so. Therefore, SD did not sustain an economic loss as a result of providing the attendant care services to YD. Accordingly, this part of the test is also not met.

56. I conclude, based on the answers to the above three requirements, that there is no period for which attendant care benefits satisfy the requirements of the Schedule because they were not "incurred" and are not eligible for coverage.

57. I also note that the applicant has not made any substantive submissions on whether the attendant care benefit is reasonable and necessary. She simply states that she has incurred the attendant care expenses. However, having concluded that the applicant expenses do not meet the definition of incurred, I need not decide if the attendant care costs are reasonable and necessary.

58. The second and final substantive issue in this case is the request to be reimbursed for the cost of examination which I will now discuss.

**Cost of Examination - Is the applicant entitled to the cost of examination in the amount of $1,971.78 by Synoptic Medical Assessments Inc. for updated in-home assessment and attendant care needs?**



59. The applicant submits that pursuant to s. 25 of the Schedule she is entitled to the cost of examination for an updated attendant care assessment dated June 27, 2016, as the report assisted in the determination of SD's entitlement to attendant care benefits and also the fees charged are reasonable.

60. In response, the respondent says that the applicant is not entitled to the cost of examination for an attendant care assessment as this disputed treatment plan was properly denied based on a Section 44 In-Home Assessment of Harish Sharma of May 30, 2016, in which he opined that SD was no longer required any attendant care assistance.

61. Section 25(1)1 of the Schedule states the following:

> (1) The insurer shall pay the following expenses incurred by or on behalf of an insured person.
>
> 4. Reasonable fees charged by an occupational therapist or a registered nurse for preparing an assessment for attendant care needs under section 42, including any assessment or examination necessary for that purpose.

62. For four main reasons, the claim for the cost of the examination is dismissed.

63. First, the applicant's submissions to the Tribunal are devoid of explanation why the entire amount of $1,971.78 is reasonable and necessary expense. The onus is on the applicant to prove entitlement to the specific benefits that she is claiming. In her written submissions, the applicant states that the fees charged by the occupational therapist who prepared the report are reasonable. In her verbal submissions, the applicant's representative stated that assessment was necessary to respond to Aviva's assessment that found that SD no longer required care assistance. I do not find her submissions to be persuasive because she has not stated what specific evidence she is relying upon that comes to this conclusion. More is required to allow the applicant to meet her evidentiary burden.

64. Second, I accept the conclusion of the IE assessment that the treatment plan was not reasonable and necessary because the applicant was independent with her personal care activities and all other tasks listed in the Form 1. Indeed, the applicant's own assessor on July 27, 2017 concluded that YD "has resumed independence in majority of her self-care activities, albeit with increased time and effort due to pain and fatigue."

65. Third, by June 2016, (when this treatment plan was requested), the preponderance of the medical evidence all pointed to the applicant having made significant progress in her overall recovery, including that she: (i) suffered fracture of the metatarsal and tibia that were treated successfully with a cast and did not require surgery; (ii) was discharged from the fracture clinic 3 months after the accident and did not have to follow up except for advice on orthotics; (iii) that she did not require crutches or a wheelchair any longer; and (iv) only made two visits to her family doctor after her accident, neither of these visits related to any accident related issues.

66. Fourth, the surveillance video completed in August/September 2016 showed the applicant walking feely, cleaning and lifting a green garbage bin, independently driving, shopping and carrying several grocery bags and loading them into her car, and gardening (pulling weeds) for about 40 minutes. This despite, Ms. Legasi expressing in her updated report dated July 27, 2016, a mere few weeks prior that YD was fearful of driving and has not returned to driving since the accident. SD's participation in all of these activities appear to be a strong indicator of her being independent of her self-care needs.

67. Based on the totality of the evidence before me, I find that the treatment plan for an in-home attendant care assessment was not reasonable and necessary.

## Estoppel By Convention

68. The position advanced by the applicant in her submissions is fundamentally an argument of the merits of ordering the insurer to pay for the attendant care benefits based on principles of fairness and equity. In other words, the applicant has asked the Tribunal to ignore substantive statuary provisions (ie. s. 3(7)(e) of the Schedule) and adopt another norm which produces a more satisfactory result.

69. It is a well-accepted principle that an administrative tribunal has only the powers conferred to it by statute.[10] The jurisdiction of a statutory tribunal must be found in a statute and must extend not only to the subject matter of the application and the parties, but also to the remedy sought. As a creature of statute, the *Licence Appeal Tribunal* ("LAT") only has such powers as have been given it by or under its enabling legislation.[11]

70. Section 5.1(4) of the *Licence Appeal Tribunal Act*[12] states:

> Jurisdiction

[10] *Douglas/Kwantlen Faculty Assn. v. Douglas College*, [1990] 3 S.C.R. 570.
[11] *086891 Ontario Inc. v. Barber,* 2007 CanLII 18734 (ON SCJ).
[12] *Licence Appeal Tribunal Act,* R.S.O. 1999, c. 12.

> (4) The Tribunal has jurisdiction to determine all questions of fact or law that arise in matters before it.

71. The *Statutory Powers Procedures Act*, *Licence Appeal Tribunal Act*, *Insurance Act*, and LAT *Rules of Practice* do not seem to confer additional powers to the tribunal to delegate that jurisdiction. Put simply, there is no general equitable jurisdiction created by any of these statutes. Undeniably, equitable remedies are so extraordinary, and potentially far-sweeping in scope, that the conferral of such a power on any tribunal must be expressed in clear and explicit language.

72. Therefore, I hold that the equitable remedy requested by the respondent lies beyond the scope or authority of the LAT to award. The LAT being a creature of statute, is limited to the jurisdiction expressly granted by the enabling legislation. It has no classic equitable jurisdiction. Its enabling statute, or in conjunction with the *Statutory Powers Procedure Act*, or even its *Rules of Practice* do not provide the tribunal to administer rules of equity or the common law. Consequently, in my view, the LAT cannot entertain the notion of any sort of estoppel against the insurer and must rely on its enabling statute for all for all the power it seeks to exercise over the subject-matter of the application and the remedy sought.

## Conclusion

73. The applicant is not entitled to an attendant care benefits in the amount of $6,000.00 per month for the period of May 23, 2017 to July 27, 2016.

74. The applicant is also not entitled to an attendant care benefits in the amount of $1,797.786, per month for the period of July 28, 2016 to December 31, 2016.

75. The applicant is not entitled to the cost of an examination in the amount of $1,797.78 submitted by Synoptic Medical Assessments Inc., for an In-Home Assessment and Attendant Care Needs report.

76. As a result of this conclusion, the applicant is not entitled to interest.

77. The equitable remedy requested by the applicant lies beyond the scope or authority of the LAT to award.

78. Therefore, the application before the Tribunal is dismissed.

**Released:** June 22, 2017

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**Cezary Paluch, Adjudicator**