Safety, Licensing Appeals and Standards Tribunal Ontario
Licence Appeal Tribunal

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Ontario

RECONSIDERATION DECISION

Before: Linda P. Lamoureux, Executive Chair

Date: September 6, 2018

File: 17-003774/AABS

Case Name: B.H. v. Aviva Canada Inc.

Written Submissions By:

For the Applicant: David Donnelly

For the Respondent: Marianne D. Davis

Overview

1. The applicant, B.H., claims a number of medical benefits under the *Statutory Accidents Benefits* Schedule, O. Reg. 34/10 (the "Schedule") outlined in two Treatment and Assessment Plans. He argues that his insurer, Aviva Canada Inc. ("Aviva"), denied the plans and requested an insurer's examination ("IE") without providing adequate reasons for doing either. For that same reason, he refused to attend the IE and commenced this application.

2. The Licence Appeal Tribunal ("Tribunal") disagreed with him. It held that Aviva's reasons for denying the plans and requesting the IE were adequate. The Tribunal sought submissions from the parties on whether, as a result, this application should be dismissed. Following that request, B.H. asked me to reconsider the Tribunal's decision.

3. As explained below, I find that the Tribunal's decision involved a significant error. Measured against the strict standard required under the *Schedule*, Aviva's reasons for denying the plans and requesting an IE were inadequate. Accordingly, I cancel the Tribunal's order.

The Facts

4. The facts are straightforward.

5. The applicant was involved in a motor vehicle accident on March 2, 2014. He was driving through an intersection when a minivan t-boned his truck's passenger side. Immediately after the accident, he went to a local hospital where he was discharged by Dr. Ziad Qaseer (physician) with a diagnosis of "lower back pain soft tissue injury."

6. That lower back pain persisted. Two months later, Dr. Ronald Batte (chiropractor) completed a Disability Certificate (OCF-3) in which he described the applicant's injuries as, among other things, "injury of nerve root of lumbar spine cord" and "whiplash associated disorder [WAD 2]." Dr. Batte also completed a Treatment Confirmation Form (OCF-23) noting the same injuries, along with "[d]islocation, sprain and strain of joints and ligaments of lumbar spine and pelvis."[1] The applicant incurred approximately $1,000 in treatment. The record indicates that he saw a chiropractor, but that treatment had little effect.

7. Over the next year and a half, the applicant continued to suffer from the same lower back pain. For example, the record discloses the following:

[1] This same injury appears to have been noted in the OCF-3, but the description is cut-off.

- he underwent insurer examinations in both September and November 2014, both of which noted that he complained of upper neck and central low back pain and that he used a cane and walked slowly. Indeed, the second IE determined that the applicant had developed whiplash associated disorder 2 of the neck and "nonspecific low back pain;"

- in a letter dated August 6, 2015, Dr. Qaseer confirmed that he assessed the applicant on that date and that "it is obvious that [his] physical condition is quite affected and limited by his lower back pain and neck pain," and that his "prognosis is quite guarded due to the chronicity of symptoms and the lack of improvement;"

- the following month, on September 28, 2015, Dr. Qaseer completed a Health Status Report that again noted the applicant's lower back and neck pain; and

- at Dr. Qaseer's request, the applicant saw Dr. Brian O'Doherty (physiatrist), who in November 2015 also noted the applicant's lower back and neck pain, along with his slow gait and use of cane.

8. In May 2016, the applicant saw Leanne Farrell (OT), who provided him with an in-home OT consultation, following which she produced a detailed report dated May 10, 2016. In her report, Ms. Farrell described the applicant's condition as follows:

> [The applicant] presents with ongoing challenges with low back pain, pain in his right thigh with standing – resulting in impaired sitting and standing tolerance. He walks very slowly with support of a single point cane. He demonstrates difficultly coping with meals and tasks such as cleaning his home and changing his bedding due to his back/thigh pain. He does not have a comfortable chair in his apartment and thus has no supportive, comfortable place to sit. [The applicant] indicated that he spends quite a lot of time lying down to try to manage his pain. However, his mattress is soft and provides poor support.

9. Based on her observations, Ms. Farrell completed the two Treatment and Assessment Plans (OCF-18s) at issue, both dated June 21, 2016. The first recommends certain assistive devices and occupational therapy for a total of $1,547.25. The second recommends a new power recliner and sleep system at a cost of $3,415.41.

10. Aviva denied both. In its letter of July 8, 2016, Aviva explained to the applicant that it was "unable to determine whether the recommendations are reasonably required for the injuries you received in this motor vehicle accident." It also offered the following "medical reason" for its denial: "the type(s) of treatment does not appear consistent with the patient's diagnosis." At the same time, Aviva scheduled the applicant for an IE with an occupational therapist.

11. In response, the applicant took the position that he did not receive adequate reasons for either the denials or the need for an IE. He also repeatedly asked Aviva to clarify its reasons. Aviva refused. The applicant then commenced an application to the Tribunal. A preliminary hearing was eventually scheduled to determine whether Aviva's reasons complied with s. 38(8) and s. 44(5) of the *Schedule*.

12. The Tribunal held that they did and therefore Aviva's reasons were adequate. Applying *Augustin v. Unifund Assurance Co.*,[2] the Tribunal found that Aviva's reasons indicated that it had "considered the treatment and assessment plans in light of the medical documentation on file," and was "unable to satisfy itself that the proposed plans are consistent with the applicant's diagnoses injuries:"

13. I disagree.

Decision and Reasons

14. I recently considered the effect of both s. 38(8) and s. 44(5) of the *Schedule* in 16-*003316/AABS v. Peel Mutual Insurance Company.* [3] In that decision I addressed the evolution of these sections and the insurer's resulting obligations to provide the "medical reasons and all of the other reasons" for denying a treatment plan at paras. 17 – 22 as follows:

> This section embodies a significant development. Before September 1, 2010, insurers were not obligated to provide any reason when denying an OCF-18. Instead, under the *Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996*, they could simply deny the plan and require the insured person to attend an IE. That changed with the introduction of the current *Schedule*, which was enacted to reduce the cost of unnecessary IEs. Accordingly, IEs are no longer mandatory upon denial and, subject to important limits, are now at an insurer's discretion. In turn, insurers must outline their medical and other reasons for denying a plan, an obligation that was also added in s. 44(5)(a) to qualify their ability to request an IE.
>
> When it was first introduced, s. 38(8) required insurers to provide the "medical and *any other reasons*" justifying a denial [emphasis added]. In 2013, however, the government went further. It amended the section to obligate insurers to justify any plan's denial with "the medical reasons and *all of the other reasons*" [emphasis added]. This was a small but telling change. The government obviously intended insurers to explain any denial of benefits with all applicable reasons. In doing so, it clearly sought

[2] [2013] O.F.S.C.D. No. 211.
[3] 2018 CanLII 39373.

to prevent insurers from denying treatment arbitrarily, ensure transparency in their decision-making and, most importantly, advance the *Schedule*'s ultimate aim: to ensure that injured persons have access to accident benefits as soon as possible – when they need them. As the Supreme Court of Canada has recognized, no fault insurance like the *Schedule* is "predicated upon the desire to provide accident benefits to all victims, regardless of fault, efficiently and expeditiously."

As for the precise "medical reasons" that insurers must now offer under s. 38(8), I repeat my recent comments in *M.B. v. Aviva Insurance Canada*. In that case, I considered the meaning of an insurer's requirement under s. 44(5)(a) to provide the "medical and any other reasons" justifying a request for an IE. I explained how that requirement was "obviously part of a legislative trend that has obligated insurers to justify their requests for IEs with progressively greater detail and clarity," and should therefore "be interpreted accordingly, particularly given the fact that the *Schedule* constitutes remedial and consumer protection legislation." The same applies here. I also attempted to provide general guidance as to how an insurer satisfies its obligation to furnish its "medical and any other reasons" for requesting an IE:

> In my view, an insurer satisfies its obligation to provide its "medical and any other reasons," whether under s. 44(5)(a) or elsewhere, by explaining its decision with reference to the insured's medical condition and any other applicable rationale. That explanation will turn on the unique facts at hand. Therefore, it would be unwise to attempt to outline a comprehensive approach to doing so. Nevertheless, an insurer's "medical and any other reasons" should, at the very least, include specific details about the insured's condition forming the basis for the insurer's decision or, alternatively, identify information about the insured's condition that the insurer does not have but requires. Additionally, an insurer should also refer to the specific benefit or determination at issue, along with any section of the *Schedule* upon which it relies. Ultimately, an insurer's "medical and any other reasons" should be clear and sufficient enough to allow an unsophisticated person to make an informed decision to either accept or dispute the decision at issue. Only then will the explanation serve the *Schedule*'s consumer protection goal.

> Again, although I made those comments in a different context, their substance is equally applicable to denials under s. 38(8).
>
> The ultimate purpose underlying s. 38(8) is to require an insurer to respond to a treatment plan not only quickly but also reasonably, in a manner that respects an insured's ability, when entitled, to access timely treatment. To that end, an insurer's "medical reasons" for denying a plan should engage the specific details about the insured's condition forming the basis for the insurer's decision. They should also be adequate enough to allow an unsophisticated person to understand them and make an informed decision in response. Those entitled to accident benefits should not have to wonder why they are denied treatment. Nor should they have to incur the temporal, emotional, and financial costs associated with engaging the Tribunal in order to obtain the treatment they should have received long before. If s. 38(8) is to achieve its purpose, it must require insurers to accompany any denial of benefits with meaningful and accurate reasons based on an insured's medical condition as described in the file at hand.
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> In evaluating the sufficiency of such notice, the Tribunal should be mindful of those who adjust insurance files. It would be naïve or impractical or to expect them to articulate something resembling a medical opinion. Likewise, their reasons should not be measured by the inch or held to a standard of perfection. Moreover, reasonable minds may disagree about the content of an insured's file. Those allowances should be made. If it offers a principled rationale based fairly on an insured's file, an insurer will have satisfied its obligation under s. 38(8).

15. Aviva's denial letter of July 8, 2016 falls short of this mark.

16. To begin, Aviva simply explained to the applicant that it was "unable to determine whether the recommendations are reasonably required for the injuries you received in this motor vehicle accident." It offered a single "medical reason" for its denial: "the type(s) of treatment does not appear consistent with the patient's diagnosis."

17. Aviva's letter does not explain in any meaningful way why Aviva is "unable to determine whether the recommendations [included in the plans] are reasonably required for [the applicant's] injuries" or why "the type(s) of treatment does not appear consistent with the patient's diagnosis." Indeed, when read together, both sentences appear incongruous: either Aviva cannot determine whether the benefits are necessary, or it can but has determined that the benefits are inappropriate given the applicant's condition. Moreover, both reasons only raise obvious questions about Aviva's decision. For example, what medical information

did Aviva rely on to make its determination, or what specifically is the inconsistency between that information and the recommended benefits? The answers to those questions should have been made clear.

18. More importantly, the benefits included in the second OCF-18, along with the assistive devices and part of the therapy included in the first OCF-18, are entirely consistent with the applicant's diagnoses of low back pain. At best, only a part of the therapy recommended in the first OCF-18 is unnecessary given that, as Ms. Farrell explained, it is intended to address injuries or symptoms that have never been previously documented, namely issues that the applicant now appears to suffer with his memory and attention. I can speculate that this might be why Aviva offered, "the type(s) of treatment does not appear consistent with the patient's diagnosis." However, that is unclear given the sparse reasons that Aviva offered. At any rate, that explanation – which Aviva has never offered – is only apparent on a reading of the record as a whole. To give effect to this justification now would run counter to the *Schedule*'s consumer protection objective.

19. For these reasons, I find that Aviva failed to satisfy is obligation under s. 38(8) of the *Schedule*. The Tribunal's interpretation of that obligation would essentially allow an insurer to justify any denial of a plan by merely stating that it had reviewed the plan in light of the medical documentation on file and, without providing any meaningful detail, assert that the plan was not appropriate given the insured's condition. This was a significant error of law within the meaning of rule 18.2 of the Tribunal's *Rules of Practice and Procedure.*

20. Given the lack of proper notice, and for the reasons I explained in *M.F.Z. v Aviva Insurance Canada*,[4] the mandatory consequence outlined in s. 38(11)2 of the *Schedule* applies.

21. Lastly, given my findings and the operability of s. 38(11)2, there is no need for me to consider whether Aviva's notice complied with s. 44(5). If I were required to make that determination, I would have found Aviva's notice inadequate for the same reasons discussed above.

[4] 2017 CanLII 63632 at para. 58 *et seq.*

Conclusion

22. This request for reconsideration is granted. The Tribunal's order is cancelled.

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

Released: September 6, 2018