Citation: He v. Aviva Insurance Company of Canada, 2022 ONLAT 19-010082/AABS

Licence Appeal Tribunal File Number: 19-010082/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:

Jian Chao He

Applicant

and

Aviva Insurance Company of Canada

Respondent

DECISION AND ORDER

ADJUDICATOR: **Theresa McGee, Vice-Chair**

APPEARANCES:

For the Applicant: Yu Jiang, Paralegal

For the Respondent: Jessica Bacopulos, Counsel

HEARD: **By way of written submissions**

BACKGROUND

[1] The applicant, Jian Chao He, was involved in an automobile accident on March 14, 2017, and sought benefits from the respondent, Aviva Insurance Company of Canada, pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010*[1] (the "*Schedule*").

[2] The respondent denied the applicant's claims for a non-earner benefit and certain medical benefits. The applicant has applied to the Licence Appeal Tribunal ("Tribunal") for resolution of the dispute.

ISSUES

[3] The issues to be decided are:

a. Is the applicant entitled to a non-earner benefit in the amount $185.00 per week from April 11, 2017 to date and ongoing?

b. Is the applicant entitled to a medical benefit in the amount of $5,377.66 for physiotherapy recommended by Total Recovery Rehab in a treatment plan (OCF-18) submitted on February 28, 2019 and denied on April 30, 2019?

c. Is the respondent liable to pay an award under Regulation 664 because it unreasonably withheld or delayed payments to the applicant?

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

RESULT

[4] The applicant has proven entitlement to the disputed physiotherapy. Although the applicant has not established that he suffers a complete inability to carry on a normal life, the respondent is liable to pay the applicant a non-earner benefit in the amount of $185.00 per week from April 11, 2017 to September 27, 2017 for failing to respond to the applicant's claim within the timelines prescribed by s. 36 of the *Schedule*. Interest is payable on the benefits owing and shall be calculated in accordance with s. 51 of the *Schedule*. There is no basis for an award.

[1] O. Reg. 34/10.

ANALYSIS

The applicant does not meet the disability test for a non-earner benefit

[5] The disability test for a non-earner benefit is set out in s. 12(1) of the *Schedule*. To be eligible for this benefit, an applicant must prove, on a balance of probabilities, that as a result of and within 104 weeks of the accident, he suffers a "complete inability to carry on a normal life."

[6] Section 3(7)(a) of the *Schedule* provides that a person suffers a complete inability to carry on a normal life as a result of an accident if, as a result of the accident, the person sustains an impairment that continuously prevents the person from engaging in substantially all of the activities in which the person ordinarily engaged before the accident.

[7] In *Heath v. Economical Mutual Insurance Company* ["*Heath*"],[2] the Ontario Court of Appeal set out general principles to assist triers of fact in interpreting and applying the non-earner benefit provisions. *Heath* urges a claimant-focused inquiry that reflects the high threshold created by the language of the *Schedule*.

[8] This interpretive approach starts with a comparison of the claimant's activities and life circumstances over a reasonable period before and after the accident. A "reasonable" time period pre-accident will depend on the facts of each case, but more than a "snapshot" will be required. While all the claimant's ordinary pre-accident activities should be considered, greater weight may be assigned to those activities which the claimant identifies as being important to their pre-accident life.

[9] To establish a "complete inability to carry on a normal life," the claimant must also prove an uninterrupted accident-related disability or incapacity. But the phrase "engaging in" is to be interpreted qualitatively. Merely "going through the motions" of an activity will not amount to engaging in it.

[10] An application of the *Heath* principles to this case is hampered by the lack of evidence detailing the applicant's pre-accident circumstances and activities. The record provides an insufficient basis for a finding of continuous impairment in all areas of the applicant's life.

[11] The applicant submits that his diagnoses alone – multiple fractures, chronic pain, and psychological disorders – are sufficient to explain how he meets the test for disability. He relies on a Disability Certificate (OCF-3) submitted March 28, 2017

[2] 2009 ONCA 391.

and prepared by Dr. Counti, a chiropractor, which states that he suffers a complete inability to carry on a normal life due to markedly decreased head, neck, upper right extremity, and trunk movement and excessively high pain scales.

[12] A list of diagnoses cannot support the thorough contextual analysis required by *Heath*. The applicant submits that although he is able to do things, he cannot genuinely engage in *any* of his pre-accident activities due to accompanying pain. As the Court of Appeal observed in *Galdamez v. Allstate Insurance Company of Canada*,[3] the *Schedule* requires that an applicant show an inability to engage in "substantially all" (not "all") of his pre-accident activities to qualify for a non-earner benefit. Although the evidence before me references minor adjustments to the applicant's routines, it does not establish that the applicant is unable to engage in "substantially all" of his activities.

[13] For example, the applicant reported to assessors during the multidisciplinary Insurer's Examinations in November 2017 that, post-accident, his wife assists with grocery shopping, but he also stated that this is because she now works at a grocery store. He reported that his wife and daughter assist with heavier household tasks, but that he will do them if he has to.

[14] The applicant relies on an Attendant Care report dated March 30, 2017 completed by Ariadna Randall, a registered nurse. In the report, Ms. Randall states that the applicant has "extreme difficulty with many tasks" and is "unable to perform many tasks of the physical tasks associated with his physical care/housekeeping duties." However, it is clear from the report that Ms. Randall did not observe the applicant attempting personal care or housekeeping tasks. Instead, for almost every task assessed, the report states, "based on formal and non formal observation/testing the patient *would have difficulty* with this task" (emphasis added). The assessment is, in my view, of limited weight given that it is not based on direct observation of the tasks assessed. It also lends little insight into the applicant's pre-accident life other than to say that he carried out most household tasks. The evidence does not suggest that the applicant's impairment continually prevented him from engaging in these activities.

[15] The applicant has not tendered sufficient evidence to establish a baseline of his pre-accident activities. The evidence he has presented falls short of establishing that he was continually prevented from engaging in substantially all of his pre-accident activities. Without more detail as to the applicant's pre-accident life and

[3] 2012 ONCA 508 at para. 39.

post-accident functioning, I am unable to conclude that he meets the *Heath* test of a having a "complete inability to carry on a normal life."

The respondent failed to comply with the notice period in s. 36 of the *Schedule*

[16] The applicant submits that he is entitled to payment of a non-earner benefit because the respondent failed to comply with s. 36(4) and (5) of the *Schedule*. These provisions require an insurer, within 10 days of receiving a completed application and Disability Certificate (OCF-3), to pay the benefit, give notice of non-payment with reasons, or send a request for information under s. 33. The applicant submits that when the respondent did give notice of its denial, it failed to provide adequate medical reasons for its refusal to pay the benefit, and as a result under s. 36(6), it is liable to pay the non-earner benefit until such time as the respondent complies with the section.

[17] I find that the respondent is partially liable for the claimed non-earner benefit because it failed to give notice of its denial within 10 days as required under s. 36 of the *Schedule*. When it did give notice of its denial on September 27, 2017 (approximately six months later), the respondent satisfied the requirement to provide the "medical and any other reasons" for the denial. I find that this notice cured the respondent's non-compliance with s. 36.

[18] The applicant has tendered evidence to show that it submitted to the respondent an Election of Benefits (OCF-10) on March 21, 2017 and a Disability Certificate (OCF-3) that was positive for non-earner benefit entitlement on March 28, 2017. These two documents satisfy the requirements for a non-earner benefit application under s. 36 of the *Schedule*, triggering the insurer's 10-day window to provide a response.

[19] The respondent did not deny the applicant's claim for a non-earner benefit until September 27, 2017. This was a provisional denial pending the completion of an Insurer's Examination satisfying the notice requirement in s. 36(4)(b). The final denial came on November 17, 2017, citing the respondent's reliance on a multidisciplinary Insurer's Examination report (physiatry, psychology, and occupational therapy). The report was enclosed with the denial, which stated:

> [1] Please find enclosed the section 44 report dated November 9, 2017 from Viewpoint. The report was completed by Dr. Day, Dr. Ko and Robert Campos. The assessors have concluded you do not suffer a complete inability to carry on a normal life. Therefore, you do not qualify for the non-earner benefit.

> [2] Please review the enclosed report for a detailed explanation of the assessors' opinions and findings.

[20] I find no deficiency in the respondent's reasons for denial. Section 36(4)(b) requires the insurer to provide the "medical and any other reasons" why it does not believe the applicant is entitled to the specified benefit. The respondent's reasons were clear and straightforward. They referenced the relevant disability test and the opinions of the assessors upon which the denial was based. The respondent enclosed the report for the applicant to review. The reports are detailed and explain the assessor's findings that from a physical, psychological, and functional perspective, the applicant did not suffer a complete inability to carry on a normal life.

[21] The respondent makes no submissions directly addressing its failure to respond within 10 days of the applicant's non-earner benefit claim. Absent evidence to the contrary, I find that the applicant properly claimed the non-earner benefit on March 28, 2017. The respondent had 10 days from that date, or until April 7, 2017 to respond to the claim, but I see no evidence that it did so.

[22] There is a four-week waiting period from the onset of disability for the payment of a non-earner benefit under s. 12 of the *Schedule*. The Disability Certificate (OCF-3) that the applicant submitted in support of his claim indicated that the date of onset of his disability was March, 14, 2017, the date of the accident. In this case, the waiting period would have expired on April 11, 2017.

[23] To conclude, even though the applicant does not meet the disability test for entitlement to a non-earner benefit, I find that the respondent is liable to pay the applicant a non-earner benefit for 21 weeks and one day, from April 11, 2017 when the waiting period expired until September 27, 2017 when it cured its non-compliance with s. 36. The benefit is payable at a rate of $185.00 per week plus interest calculated in accordance with the *Schedule*.

The applicant is entitled to the disputed physical therapy

[24] To be eligible for the physiotherapy treatment he seeks, the applicant must demonstrate on a balance of probabilities that the proposed physical therapy is reasonable and necessary as a result of the accident, as required under s. 15 of the *Schedule*. The disputed treatment plan amounts to $5,377.66 for 14 sessions of physiotherapy and massage therapy. The plan was submitted to the respondent on February 28, 2019.

[25] The applicant relies on the January 25, 2019 recommendation of his family physician, Dr. King Sun Chan, that he pursue physiotherapy and massage therapy to treat his chronic back pain. The respondent submits that the clinical notes and records of the family physician are largely illegible and should be given no weight. While I agree that the handwritten clinical notes are illegible, Dr. Chan did complete a referral form that clearly recommends physiotherapy and massage therapy to treat the applicant's back pain. The referral was made just weeks before the disputed treatment plan was submitted to the respondent.

[26] I attach significant weight to the recommendation of Dr. Chan as the applicant's primary care physician. The applicant's persistent accident-related pain is documented elsewhere in the record. The applicant attended a consultation at the neurology clinic at Princess Margaret Hospital several months after the treatment plan was submitted. The consulting neurologist noted the applicant's three-year history of accident-related back pain and recommended a possible referral to a chronic pain clinic to assist in the management of his symptoms.

[27] I am alive to the respondent's submission, based on the opinion of its physiatry and occupational therapy assessors, that the applicant showed no ongoing impairment and no functional impairment, I attach greater weight to the clinical findings and recommendations of the applicant's OHIP-funded treating and consulting practitioners. The applicant has satisfied his onus, on a balance of probabilities, that physiotherapy and massage therapy were reasonable and necessary interventions for the treatment of his accident-related injuries in February 2017 when they were proposed.

There is no basis for an award

[28] The applicant claims an award under s. 10 of Regulation 664. Regulation 664 empowers the Tribunal to order payment of a lump sum by an insurer to an insured person if the insurer has unreasonably withheld or delayed payment of benefits. The well-established standard for granting an award under Regulation 664 is set out in the Financial Services Commission of Ontario case of *Plowright v. Wellington Insurance Co* [*Plowright*].[4] An award is appropriate where an insurer has engaged in conduct that is excessive, imprudent, stubborn, inflexible, unyielding, or immoderate.

[29] The record before me does not establish conduct of this nature. The applicant submits that an award is justified because the respondent denied his claims for a non-earner benefit and medical treatment without reasonable explanation or

[4] 1993 OIC File No.: A-003985 (FSCO).

reassessment, and, in doing so, it breached its duty to the applicant of good faith and fair dealing.

[30] Although I have found one of the respondent's denials of the applicant's claims (the physiotherapy claim) to be ultimately unfounded, I do not consider the respondent's denials to be unreasonable. As I have explained, the applicant did not meet his burden in establishing a baseline of pre-accident activities that would support a non-earner benefit claim. There is no requirement for an insurer to subject each individual benefit claim to Insurer's Examinations. Even though the respondent failed to give timely notice of its denial of the non-earner benefit, I do not consider this noncompliance to be evidence of bad faith or conduct of the nature described in *Plowright*. I see no basis for an award.

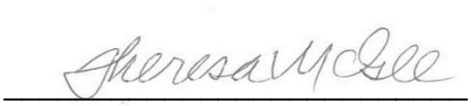
CONCLUSION AND ORDER

[31] The respondent shall pay the applicant a non-earner benefit from April 11, 2017 to September 27, 2017, a period of 24 weeks and one day, payable at a rate of $185.00 weekly for a total of $3,911.43 plus interest.

[32] The respondent shall also fund the disputed Treatment and Assessment Plan (OCF-18) in the amount of $5,377.66 plus interest.

[33] In total, the respondent is liable for $9,289.09 plus interest. Interest shall be calculated in accordance with s. 51 of the *Schedule*.

Released: April 27, 2022



Theresa McGee
Vice-Chair