LICENCE APPEAL TRIBUNAL

Safety, Licensing Appeals and Standards Tribunals Ontario

TRIBUNAL D'APPEL EN MATIÈRE DE PERMIS

Tribunaux de la sécurité, des appels en matière de permis et des normes Ontario

Citation: **Lu Lu Sun vs. Aviva General Insurance Company, 2019** ONLAT **18-005357/AABS**

Date: August 2, 2019
File Number: 18-005357/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:

Lu Lu Sun

Appellant(s)

and

Aviva General Insurance Company

Respondent

DECISION AND ORDER

PANEL: **Maureen Helt, Vice Chair**

APPEARANCES:

For the Applicant: Lu Lu Sun, Applicant
Philip Kai Kwong Yeung, Paralegal

For the Respondent: Ramandeep Pandher, Counsel

HEARD: **In Writing on: December 3, 2018**

REASONS FOR DECISION

OVERVIEW

[1] The applicant was involved in an automobile accident on October 21, 2015, and sought benefits pursuant to the Statutory Accident Benefits Schedule - Effective September 1, 2010 (the "Schedule"). The applicant was denied certain benefits by the respondent and applied to the Licence Appeal Tribunal - Automobile Accident Benefits Service ("Tribunal").

[2] The applicant was in her vehicle, which was stationary in a residential driveway, when she was struck by another vehicle. Following the collision, the applicant was transported by ambulance to the hospital where she was seen in the emergency department.

[3] The applicant claims benefits from her insurer with respect to a treatment and assessment plan for chiropractic services as well as a claim for the cost of an emergency room visit at the Scarborough Hospital in May, 2016, some seven months after the accident.

[4] At the case conference held in September 2018, the respondent raised three preliminary issues to be considered in conjunction with the substantive issues as part of this written hearing.

PRELIMINARY ISSUES

[5] The preliminary issue as set out in the case conference order dated September 20, 2018 are as follows:

(i) Is the applicant barred from proceeding with the application due to failure to attend insurer examinations pursuant to s. 55(1) of the Schedule?

(ii) Is the applicant time-barred from commencing the application pursuant to s.56 of the Schedule?

(iii) Is the applicant barred from commencing an application at the Tribunal due to non-compliance with s.33 information requests?

[6] The case conference order set dates for the filing of submissions on the preliminary and substantive issues. In its responding submissions the respondent states that the preliminary issue of failure to attend insurer examinations is no longer an issue as the applicant withdrew her claim for income replacement benefits.

[7] The remaining preliminary issues with respect to s. 33 and s. 56 of the Schedule are addressed below in the consideration of the substantive issues. The necessary factual context for considering the preliminary issues makes their consideration more properly dealt with as part of the substantive issues.

SUBSTANTIVE ISSUES

(i) Is the applicant entitled to payment in the amount of $2,819.08 for chiropractic services provided by Perfect Physio and Rehab Centre, as set out in a treatment and assessment plan dated April 13, 2016 and denied by the respondent on June 13, 2016?

(ii) Is the applicant entitled to payment in the amount of $630.00 for hospital services submitted on May 12, 2016 and denied by the respondent on May 26, 2016?

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

ANALYSIS

(i) **Treatment and Assessment plan dated April 13, 2016 for chiropractic services**

[8] After the accident on October 21, 2015, the applicant attended the emergency room at the hospital and was found to have sustained a possible concussion. On October 24, 2015 she attends at MCI The Doctors Office noting concerns of persisting headaches, vomiting, numbness in her hands, and pain at her right flank. She then went to the hospital again and was examined by another emergency doctor. She was diagnosed with concussion.

[9] She began to experience neck, shoulder, back and hip pain in days following the accident.

[10] In January 2016 the applicant continued to present with concerns of dizziness, headaches, pain in her neck, shoulders and back and limited range of movement at her cervical spine, lumbar spine and shoulder region.

[11] April 2016 the applicant consulted Dr. R. Tavares at Perfect Physio. Dr. Tavares submitted a treatment and assessment plan dated April 13, 2016 recommending additional chiropractic services and active therapy. He found the applicant to have minimal-moderate improvement with continued impairment at the shoulder region, and cervical, thoracic and lumbar spine. Barriers to recovery were noted as persistence of symptoms, psychological factors, and multiple sites of injury.

[12] In a letter dated April 28, 2019, the respondent noted that there was no compelling evidence that the treatment plan requested was reasonable and necessary and advised that it needed to conduct a section 44 examination.

[13] A Notice of Examination was sent to the applicant on May 9, 2016 for an insurer examination to determine if the treatment plan was reasonable and necessary. There is no dispute that this Notice was received by the applicant.

[14] Dr. Rusen, conducted a paper review s. 44 insurer examination (IE) on June 6, 2016 and in his report of June 10, 2016 states the treatment plan is not reasonable and necessary based on various documents, including his report from a paper review done on June 6, 2016 and a report of Dr. Mehdiratta, a neurologist who conducted an IE examination dated June 6, 2016. The applicant states it never received these two reports.

[15] While the respondent submits the reports were delivered and includes a copy of the covering letter to the applicant referencing the attachment of the two respective reports in its responding submission, the applicant takes the position that the evidence put forward by the respondent is not sufficient evidence to prove that the reports were actually delivered. The applicant submits that the report of Dr. Rusen and that of Dr. Mehdiratta, both dated June 6, 2016 be excluded from the evidence.

[16] The applicant relies on section 38 of the Schedule in its submission stating that the respondent failed to provide the IE reports that were relied upon in the denial of the disputed treatment plan. As such the applicant argues that the insurer breached its duty of good faith and fair dealing with the applicant. For ease of reference s. 38 reads as follows:

> s. 38 (13) Within 10 business days after receiving the report of an examination conducted under section 44 for the purpose of the treatment and assessment plan, the insurer shall give a copy of the report to the insured person and to the regulated health professional who prepared the treatment and assessment plan. O.Reg. 34/10, s.38(13).

[17] In considering whether or not the applicant did in fact receive the disputed reports I can only refer to the evidence put before me. On the one hand the insurer has put forward two cover letters which reference the respective reports being enclosed. On the other hand, the applicant submits that the reports were never received, nor were the two cover letters.

[18] With such conflicting evidence it is not clear if the reports were sent by regular mail or otherwise. If sent by fax, the respondent could have provided a fax transmission sheet, if by email, then an email confirmation could have been provided, if by courier, then a courier slip. It appears it may have been delivered by regular mail, which is permissible however there is no affidavit or otherwise attesting to this fact.

[19] What is clear is that the onus is on the applicant to prove the treatment plan is reasonable and necessary.

[20] Even if I admit the reports filed by the respondent, I find that the applicant has established that the treatment plan is reasonable and necessary.

[21] In reviewing the reports and the respondent's submission the position being advanced is that there is no evidence of ongoing accident-related orthopaedic impairment noting that the last doctor visit was in December 2015.

[22] It is the Respondent's position that the Applicant has failed to establish why this treatment plan is reasonable and necessary and has not produced any medical evidence or reports to rebut the uncontradicted opinions of the Respondent's section 44 assessors.

[23] The respondent submits that the applicant's medical records reflect an individual who was physically healed from the subject motor vehicle accident by November 2015 and that there were no additional visits to her family doctor after December 2015. The applicant disagrees and notes that the doctor noted the applicant as experiencing headaches, sleep problems due to pain, neck pain, and taking pain medication. The doctor recommended massage. An entry in December 2015 also highlights accident-related injuries (Tab 10 of the respondent's brief).

[24] The clinical notes from Perfect Physio and Rehab Centre form October 2015 sets out that the applicant had pain in the range of 9 out of 10 and was In the nature of stiff, shooting pain. The next date she attended is January 2016 which notes that the applicant continues to experience tenderness along her spinal muscles and is also experiencing pain. It notes that the applicant reports some difficulties with heavy household chores such as cleaning, vacuuming, popping, grocery shopping. She is no longer experiencing nausea or vomiting. She still has headaches, difficulties sleeping, nightmares, radiculopathy in her extremifies and some other symptoms.

[25] A March 24, 2016 letter describes the applicant's ongoing physical pain and limitations noting that she continues to have decreased range of motion in her cervical spine, thoracic and lumbar spine pain as well as rib strain and strain of shoulder region. She also complains of radicular symptoms in her bilateral arms.

[26] While I acknowledge the medical reports of Dr. Rusen and Dr. Mehdiratta find that the treatment plan for chiropractic services is not reasonable and necessary on the basis that there is no evidence of ongoing accident-related orthopaedic impairment, I find the evidence of the applicant, that the chiropractic treatment relieves pain and increases range of motion, to be more persuasive.

[27] Based on the evidence before me the goal of the chiropractic treatment was to reduce pain and increase range of motion with the functional goals of returning to normal activities. The medical evidence provided shows improvement in her range of motion and in reducing her pain. This in itself is enough to qualify as reasonable and necessary if it helps increase functionality.

[28] I am satisfied that the treatment plan in the amount of $2,819.08 for chiropractic services provided by Perfect Physio and Rehab Centre, as set out in a treatment and assessment plan dated April 13, 2016 and denied by the respondent on June 13, 2016 is reasonable and necessary.

(ii) **Payment of the Expenses of the Emergency Room Visit in the amount of $630**

[29] The cost of the applicant's emergency visit to the Mackenzie Richmond Hill Hospital on May 5, 2016 is also in dispute. At the time of the visit, which is noted to be approximately six months after the accident, the applicant did not have a valid OHIP card.

[30] The respondent argued that there was a limitation period issue as the applicant failed to apply for the benefit within two years of the denial by the respondent. The applicant argues that there was no clear denial.

[31] In its May 25, 2016 letter the respondent wrote: "We have reviewed your claim for Accident Benefits and it is unclear if the expenses captioned on the OCF-6 are a direct relation to the injuries sustained in the motor vehicle accident that occurred on/about October 21, 2015. As such, we require some additional information in order to assist us in determining your entitlement to benefits."

[32] I agree with the applicant that the language used in this letter does not amount to a clear denial of the benefit and as such the limitation period can not be used to dispute the claim.

[33] Regardless, as with the treatment and assessment plan, the onus is on the applicant to establish that the expenses are reasonable and necessary. In reviewing the claim, although reference is made to the October 21, 2015 accident, this in itself is not clear to establish that the hospital visit was clearly related to the accident. The appellant has failed to meet its onus. For this reason, I deny the applicant's claim for the hospital expense.

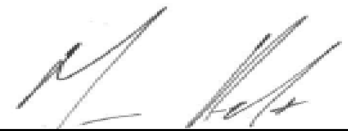
ORDER

[34] For the above reasons I order the following:

(i) The applicant is entitled to the payment of $2,819.08 for chiropractic services provided by Perfect Physio and Rehab Centre, as set out in a treatment and assessment plan dated April 13, 2016 and denied by the respondent on June 13, 2016 plus applicable interest.

(ii) The applicant is not entitled to payment in the amount of $630.00 for hospital services submitted on May 12, 2016 and denied by the respondent on May 26, 2016?

Released: August 2, 2019



Maureen Helt
Vice Chair