CITATION: Kyrylenko v. Aviva Insurance Canada, 2021 ONSC 4929
DIVISIONAL COURT FILE NO.: DC-20-515
DATE: July 14, 2021

ONTARIO
SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

Swinton, D.L. Corbett, and McKelvey JJ.

BETWEEN:		
Tymofiy Kyrylenko	Appellant	*Alon Rooz*, for the Appellant
– and –		
Aviva Insurance Canada	Respondent	*Eric K. Grossman*, for the Respondent
– and –		
Licence Appeal Tribunal	Intervenor	*Douglas Lee*, for the Intervenor
		HEARD at Toronto (by videoconference): June 16, 2021

REASONS FOR DECISION

MCKELVEY J.:

Introduction

[1] This is an appeal from a decision of the Licence Appeal Tribunal ("the Tribunal") denying certain benefits to the appellant under s. 38 of the *Statutory Accident Benefits Schedule* ("SABS"). The issue is whether the adjudicator erred by failing to apply s. 38(11) to two expenditures which were claimed by the appellant. At the conclusion of argument, we found in favour of the appellant with written reasons to follow. These are those written reasons.

Background

[2] On September 11, 2017, two OCF-18 treatment and assessment plans were submitted by the appellant to the respondent insurer ("Aviva"). The claims arose out of a motor vehicle

accident which occurred on April 20, 2017. The claims were rejected by Aviva on November 16, 2017.

[3] Section 38(8) of the SABS provides 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, and 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.

[4] It is apparent, therefore, that the response by Aviva to the claims submitted did not conform to the requirements of s. 38(8).

[5] Section 38(11) of the SABS provides as follows:

> 38(11) 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.
>
> 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).

[6] The appellant's entitlement to benefits was heard by the adjudicator on February 12, 2019 and a written decision was issued dated July 26, 2019. The hearing dealt with a number of the appellant's claims including a claim for physiotherapy treatment for $1,232.12 as well as a claim for an in-home assessment for the sum of $1,521.26. These claims related to the two OCF-18 treatment and assessment plans submitted to Aviva on September 11, 2017 and declined by Aviva on November 16, 2017.

[7] The expense for the in-home assessment was in relation to an assessment conducted on October 30, 2017. The physiotherapy treatments were started prior to September 11, 2017 (prior to the date when the claim was made to Aviva) and continued on from that date forward. It is unclear what amount is related to the time between eleven business days after the claim was submitted and November 16, 2017 when the claim was denied.

[8] In the initial hearing before the adjudicator, both of these claims of the appellant were denied.

[9] The appellant asked for a reconsideration of the initial decision including his claims under s. 38 of the SABS. This hearing took place on October 8, 2020 and a decision was delivered on that same day.

[10] On the issue of the appellant's s. 38 entitlement, the adjudicator stated as follows:

> [11] The applicant's position is that the Tribunal failed to address the issue of mandatory payment by the insurer required under Section 38(11) of the *Schedule*.
>
> [12] The applicant submitted an OCF-18 in the amount of $1,232.12 on September 11, 2017 for physiotherapy treatment, with the respondent's first response being November 16, 2017. The applicant submitted an OCF-18 in the amount of $1,521.26 for an assessment of attendant care needs, on September 11, 2017 and the respondent responded on November 16, 2017.
>
> [13] The Tribunal did address the issues of Section 38(11) in its decision. In relation to the OCF-18 relating to the $1,232.12, there were problems with some of the expenses as to when they had been incurred. Section 38(2) of the *Schedule* does not require payment for expenses before a treatment plan is submitted. The proposed expenses were also found not to be reasonable and necessary. The Tribunal set out its discussions in paragraphs (42-45) (52) of its decision. The Tribunal also followed the Supreme Court of Canada decision *Smith v. Co-Operators* (2002 SCC 30 para 1) which requires the applicant to prove its claim despite deficiencies.
>
> [14] In relation to the OCF-18, relating to the $1,521.26 for an assessment of attendant care needs, the Tribunal did not address this issue under 38(11). I therefore find there was a deficiency in the decision and that the issue of the OCF-18 for the amount of $1,512.26 for attendant needs now has to be addressed.
>
> [15] The applicant's evidence on the attendant care issue is set out in paragraph [28] of the decision. When the applicant needs help with dressing or laundry or other household chores, his wife and mother assist him. Section 19(1) of the *Schedule* requires attendant care benefits to be paid if they are reasonable or necessary. There is no evidence before the Tribunal that attendant care benefits are needed by the applicant.
>
> [16] There is no evidence put before the Tribunal that the mother or sister were professional personal care workers. There were no invoices submitted into evidence, seeking reimbursement for time spent. There was no evidence put before the Tribunal that the mother and sister suffered economic loss, as required to be produced under section 19(3) of the *Schedule* before payment.

> [17] I find therefore, that the proposed OCF-18 in the amount of $1,521.26 is not reasonable and necessary.

Appellate Standard of Review

[11] It is agreed by the parties that pursuant to s. 11(6) of Schedule G of the *Licence Appeal Tribunal Act*, SO 1999 c. C.12, an appeal from a decision of the tribunal relating to a matter under the *Insurance Act* may be made on a question of law only. The respondent agrees that the applicable standard of review in a statutory appeal from the LAT is correctness. See *Aviva General Insurance Co. v. Khan*, 2020 ONSC 1290 (Div. Crt.) at para. 3.

Analysis

[12] With respect to the claim for physiotherapy treatment, Aviva notes that it can't be held responsible under s. 38(11) for any amounts that pre-date eleven business days following submission of the claim. As the appellant failed to establish the amount incurred for the relevant time frame, Aviva submits that this claim was properly dismissed by the adjudicator.

[13] However, while the adjudicator notes at para. 13 of his reconsideration decision that there were issues as to when the expenses were incurred, he ignores the fact that some of the expenses were incurred during the time frame covered by s. 38(11). He also states that the proposed expenses were also found not to be reasonable and necessary. In our view he erred in this conclusion because s. 38(11) does not include a requirement that the expenses be reasonable or necessary. Instead, the wording of s. 38(11) is mandatory and requires an insurer to pay, "for all goods, services, assessments and examinations described in the treatment and assessment plan". In our view, s. 38(11) is akin to consumer protection legislation and is designed to protect victims of motor vehicle accidents where an insurer fails to respond within the prescribed time frame. It requires a broad and remedial interpretation. Therefore, the adjudicator ought to have directed the parties to identify those physiotherapy expenses that related to the timeframe under s. 38(11) and to have ordered payment accordingly.

[14] With respect to the claim for an in-home assessment which cost $1,521.26, there is no issue about the fact that this expense was incurred in the timeframe contemplated by s. 38(11). The adjudicator notes at para. 15 that, "there is no evidence before the Tribunal that attendant care benefits are needed by the applicant". This, however, is not the issue. The issue is whether an in-home assessment was conducted and if so, the cost of that assessment would be covered under s. 38(11).

[15] Aviva argues that there is an inconsistency between s. 38(11) and s. 25(2) of the SABS. Section 25(2) states as follows:

> 25(2) Despite subsection (1), an insurer is not required to pay for an assessment or examination conducted in the insured person's home unless the insured person has sustained an impairment that is not a minor injury.

[16] In our view there is no inconsistency between the provisions of s. 38(11) and s. 25(2). Paragraph 1 of s. 38(11) provides that if an insurer fails to give notice in accordance with subsection (8) the insurer is prohibited from taking the position that the insured person has an impairment to which the minor injury guideline applies. Thus, even though the Tribunal determined in its initial decision that the appellant's claim fell within the minor injury guideline, this provision precludes the insurer from relying on the minor injury guideline in responding to the claim by the appellant.

[17] We have therefore concluded that the adjudicator erred in law in denying the claim for the in-home assessment.

[18] As the adjudicator did not make any award under s. 38(11), he also failed to consider whether a special award was appropriate under Reg. 644, s. 10, which provides as follows:

> If the Licence Appeal Tribunal finds that an insurer has unreasonably withheld or delayed payments, the Licence Appeal Tribunal, in addition to awarding the benefits and interest to which an insured person is entitled under the Statutory Accident Benefits Schedule, may award a lump sum of up to 50 per cent of the amount to which the person was entitled at the time of the award together with interest on all amounts then owing to the insured (including unpaid interest) at the rate of 2 per cent per month, compounded monthly, from the time the benefits first became payable under the Schedule.

[19] As this matter was not addressed by the Tribunal, we remit it back to the Tribunal for its consideration by another adjudicator.

Conclusion

[20] The appeal is allowed. We order Aviva to pay the sum of $1,521.26 plus those portions of the physiotherapy expenses which fall within s. 38(8) of the SABS to the appellant, together with interest calculated according to the SABS. We remit the issue of a special award back to the Tribunal to be considered by another adjudicator. Finally, we award costs in the sum of $5,000 to be paid to the appellant by Aviva in accordance with oral reasons given on the day of hearing.

MCKELVEY J.

I agree

SWINTON J.

I agree

"D.L. Corbett J." per K. Swinton J.

D.L. CORBETT J.

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