Citation: Garcia v. Co-Operators General Insurance Company, 2022 ONLAT 20-002871/AABS- R

RECONSIDERATION DECISION

Before:	**Derek Grant**
Licence Appeal Tribunal File Number:	**20-002871/AABS**
Case Name:	**Julian Garcia v. Co-Operators General Insurance Company**

Written Submissions by:

For the Applicant:	Aurora Mancuso, Counsel
For the Respondent:	Eric Grossman, Counsel

OVERVIEW

[1] This request for reconsideration was filed by the respondent, Co-Operators. It arises out of a decision dated October 3, 2022, in which I found that the applicant, Julian Garcia ("J.G.") was entitled to a psychiatric assessment and chronic pain assessment due to Co-Operators' non-compliance with s. 38(11) of the *Schedule*. I further found that interest was payable on the overdue payment of benefits.

[2] Co-Operators submits that I erred in law such that I would have made a different decision had the error not been made. Co-Operators seeks a reconsideration that the psychiatric and chronic pain assessments are funded though OHIP, or, in the alternative, that the amount of the psychiatric assessment be limited to the $2,000.00 cap set out by s. 25(5)(a) of the *Schedule*, including the cost of completing the treatment plan being limited to $200.00 pursuant to the *Professional Services Guideline*.

RESULT

[3] Co-Operators request for reconsideration is partially granted.

[4] While I dismiss Co-Operators' request to reconsider whether the assessments are funded by OHIP, I agree with Co-Operators that the decision contained an error of law that would have resulted in a different outcome had the error not been made in respect of the total amount payable for the psychiatric assessment, within the reconsideration ground under Rule 18.2(b). Pursuant to Rule 18.4, I therefore vary the decision regarding the amount payable for the psychiatric assessment to $2,200, and consequently vary the order for interest payable under s. 51 of the *Schedule* to be based on $2,200.

ANALYSIS

[5] The grounds for a request for reconsideration are set out in Rule 18.2 of the Tribunal's *Licence Appeal Tribunal, Animal Care Review Board, and Fire Safety Commission Common Rules of Practice and Procedure, Version 1 (October 2, 2017) (as amended) ("Common Rules")*. Co-Operator's request relies on the criteria set out in Rule 18.2(b): that I made an error of law or fact ("did not consider that J.G. should first apply for collateral benefits, i.e.: OHIP; and/or, specifying that payment of the psychiatric assessment was limited to the cap set out by s. 25(5)(a) of the *Schedule*") such that the Tribunal would likely have reached a different result had the error not been made.

[6] The test for reconsideration under Rule 18.2(b) involves a significantly high threshold. It is well-settled that reconsideration is justifiable in cases where an adjudicator has made a significant legal or evidentiary error preventing a just outcome, where false evidence has been admitted, or where genuinely new and undiscoverable evidence comes to light at the conclusion of a hearing. The reconsideration process is not an opportunity for a party to ask the Tribunal to reweigh evidence or to re-argue its position where it disagrees with the decision or where it failed to satisfy its onus at first instance.

Does s. 47(2) of the Schedule apply to the costs of assessments?

[7] There is no dispute on the circumstantial evidence of J.G.'s involvement in an accident, or my finding on the impact of his impairments sustained as a result of the accident. My decision found that J.G.'s injuries were predominantly minor, and there was no entitlement to the remaining treatment plans. Co-Operators does not dispute that the denial letters for the psychiatric assessment and chronic pain assessment did not cite the application of the Minor Injury Guideline ("MIG").

[8] Co-Operators argues that the two treatment plans are subject to collateral coverage under OHIP and therefore the Tribunal should have decided against payment to the applicant. While that may be an arguable point, Co-operators did not raise that at the hearing below. On the evidence, Co-Operators did not make any request to J.G. to seek funding from OHIP for coverage of the assessments in its denial letters, or that it was relying on s. 47(2) of the *Schedule* for payment of a benefit for which payment is reasonably available under any insurance plan or law or any other plan or law, ie: OHIP. Co-Operators cannot, on reconsideration, now bring forward a new argument that they should have done at first instance as it relates to relying on s. 47(2).

[9] At the very least, Co-Operators should have provided some information or direction to J.G. to explain that coverage for the assessments may be available in whole or in part through OHIP. This is especially true since Co-Operators would essentially "benefit" from funding being provided by OHIP. Other than a bald assertion that OHIP applies for coverage of the assessments, there is no evidence or information relied on that clearly sets out the portions of either assessment that OHIP is intended to, or more importantly, would cover. As such, I find that Co-Operators cannot rely on s. 47(2), as this is a new argument on reconsideration and there is no evidence that these assessments would be covered in part or whole.

Does s. 25 of the Schedule apply to the cost of the psychiatric assessment?

[10] Co-Operators submits that my decision failed to consider the maximums allowable for fees charged for assessments and form completion. Its position is that had the error not been made, the decision would have a different outcome.

[11] I agree with Co-Operators.

[12] J.G. did not address this issue in his responding reconsideration submissions.

[13] Section 25(1)(3)iii of the *Schedule* provides that an insurer shall pay for expenses incurred by or on behalf of an insured person for reasonable fees charged by a health practitioner for reviewing and approving a treatment and assessment plan under s. 38, including any assessments or examinations described in the treatment plan determined to be payable by the insurer as described in subsection 280(1) of the *Insurance Act*.

[14] Section 25(3) sets out that the insurer is not liable under subsection (1) for expenses related to professional services that exceed the maximum rate or amount established under the *Guidelines*. The *Guidelines* establish a maximum fee of $200.00 for reviewing and approving a treatment plan.

[15] Section 25(5)(a) provides that despite any other provision, an insurer shall not pay more than a total of $2,000.00 plus the amount of any applicable sales tax, in respect of fees and expenses for conducting any one assessment or examination and for preparing reports in connection with it.

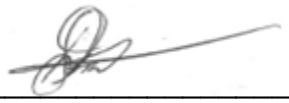
[16] On review, I agree that the decision failed to specify that J.G. was entitled to the psychiatric assessment up to $2,000.00 for the assessment, $200.00 for completion of the form, and applicable interest. Co-Operators rightly argues that the $4,946.00 amount of the psychiatric treatment plan, is above the amounts stipulated by the *Guidelines* and the *Schedule*.

[17] Accordingly, the appropriate amount that is payable is $2,200.00. Interest is payable in accordance with s. 51 of the *Schedule*. These amounts are pursuant to s. 25(5)(a) of the *Schedule* and the *Guidelines*.

CONCLUSION

[18] For the reasons noted above, I partially grant Co-Operators' request for reconsideration.

[19] Co-Operators shall pay the corrected $2,200.00 for the psychiatric assessment and applicable interest in accordance with s. 51 of the *Schedule*.



Derek Grant
Adjudicator
Tribunals Ontario – Licence Appeal Tribunal

Released: December 16, 2022