Tribunals Ontario
Licence Appeal Tribunal

Tribunaux décisionnels Ontario
Tribunal d'appel en matière de permis

Citation: Sarabi v. Gore Mutual Insurance Company, 2023 ONLAT 20-006023/AABS

Licence Appeal Tribunal File Number: 20-006023/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:

Aynoush Biniaz-Sarabi

Applicant

and

Gore Mutual Insurance Company

Respondent

DECISION

ADJUDICATOR: **Terry Prowse**

APPEARANCES:

For the Applicant: Aynoush Biniaz-Sarabi, Applicant

For the Respondent: Carla Chumney, Adjuster
Peter Durant, J.D., Counsel

HEARD: by Videoconference: **September 19, 20, 21 and 22, 2022**

OVERVIEW

[1] Aynoush Biniaz-Sarabi, (“applicant”), was involved in an automobile accident on October 24, 2017, and sought benefits from the Gore Mutual Insurance Company, (“respondent”), pursuant to the *Statutory Accident Benefits Schedule – Effective September 1, 2010 (including amendments effective June 1, 2016)* (“*Schedule*”).

[2] The applicant was denied certain benefits by the respondent, based predominantly on the results of various section 44 insurer’s examinations (“IEs”). Other benefits were denied on the basis they were previously approved, or the applicant had already undergone a similar service. The applicant applied to the Licence Appeal Tribunal – Automobile Accident Benefits Service (“Tribunal”) for resolution to the dispute.

Pre-hearing procedural issues

[3] A case conference was convened on October 28, 2020. The applicant attended self-represented, having lost two previous legal representatives. During her testimony, she explained that she was represented by a paralegal, but there was an issue with his charges, and she could not afford him anymore. She was then represented by a lawyer but was unsatisfied with his service. Apparently, the lawyer dropped her case. The applicant reports being self-represented since March 2020.

[4] According to the Case Conference Report and Order, a great deal of discussion ensued to explain various policies and procedures to her. The parties discussed what was required to initiate a determination of catastrophic (“CAT”) impairment, the purpose of a functional abilities assessment, and its application to a CAT assessment. The parties also discussed the fact that medical evidence is required to assess whether benefits, assessments or examinations are reasonable and necessary, and must support the fact that reported impairments were caused by the accident. A resumption of the case conference was scheduled for July 2021 to provide the applicant with an opportunity to seek counsel. A videoconference hearing was also scheduled for September 27 to October 5, 2021. The Order identified 17 issues in dispute to be decided at the hearing.

[5] The case conference resumed on July 20, 2021. The applicant continued as a self-represented party. Because CAT determination would not be an issue in dispute, the parties consented to amending the hearing schedule to two days, September 27 and 28, 2021.

[6] The hearing commenced on September 27, 2021. The applicant advised that she was unable to summons her witnesses. She also stated that she had not applied for a CAT determination. The respondent strongly recommended that she seek independent legal advice. To not prejudice the applicant, the hearing adjudicator determined that the best course of action would be to adjourn the hearing. The respondent did not consent. The hearing adjourned to September 19, 20, 21, 22 and 23, 2022 and a case conference was scheduled for February 18, 2022 to address any remaining production issues, clarify the issues in dispute, determine whether written submissions will be required for the hearing, and explore settlement. The applicant assured the Tribunal and the respondent that she would be prepared for the case conference and hoped to have independent legal advice by that time.

[7] Between October 2021 and August 30, 2022, the applicant submitted approximately 15 Notices of Motion to the Tribunal, as follows:

a. On October 20, 2021, she requested the production of evidence that the respondent relied on to deny a housekeeping and home maintenance benefit. On October 25, 2021, she sought the production of an IE report that was required to assess the impairment caused by her traumatic brain injury, as well as a verification of reports of "catastrophic impairment determination" that the insurer relied on to deny her caregiver benefit and specified benefits. On November 8, 2021, the applicant sought a witness summons. In a February 18, 2022 Case Conference Report and Order, the Tribunal noted that an order was not required for a summons to be issued and a motion to have the respondents' IE assessor answer questions was not appropriate, given that the applicant could call the assessor as a witness at the hearing. The request to have a CAT determination added to the hearing was denied, as the applicant had not submitted the required OCF-19 application. Lastly, the Tribunal denied the request for evidence related to housekeeping and home maintenance benefits, because these issues were not in dispute. The respondent stated that the applicant did not have optional benefits coverage, and therefore no such benefits were available, in any case;

b. On March 8, 2022, the applicant sought the production of IE reports the respondent used to deny her caregiver benefit and housekeeping benefit. She also sought any assessment reports that the respondent used to determine traumatic brain injury impairments and any neurological impairments related to spinal injuries. On March 31, 2022, the applicant sought additions to her witness list. At a motion hearing dated April 6,

2022, the Tribunal granted the request for summonses, but denied the motion for productions as they had already been provided by the respondent;

c. On April 13, 2022, the applicant sought the production of the full accident benefits file. On April 20, 2022, the applicant sought additions to her witness list, to include an adjuster, an insurance examiner and her former lawyer from November 2018 to March 2020. The applicant wished to question her former lawyer so that he could explain if he disclosed various medical reports to the insurer/insurance examiners. The motions were heard on May 30, 2022. The Tribunal granted all but the request for the applicant's former lawyer, finding that there was no relevant evidence that the lawyer could have added to the dispute;

d. On June 27th, 2022, the applicant sought the production of various treatment reports and benefit statements. On July 10, 2022, she requested to add punitive damages, exemplary damages, compensation for pain and suffering and compensation for emotional distress to the issues in dispute. On July 18, 2022, the applicant again requested productions. On July 25, 2022, she again sought an order for the respondent to pay unpaid caregiver benefits, unpaid housekeeping and home maintenance benefits, medical and rehabilitation expenses. At a motion hearing dated August 24, 2022, the Tribunal declined the order for productions, finding that the documents the applicant needed to present her arguments had already been ordered by the Tribunal and received by her. The Tribunal determined that it did not have jurisdiction to order punitive damages, pain and suffering damages or consequential damages. It also declined to add caregiver, housekeeping and home maintenance, medical and rehabilitation benefits, as issues in dispute, because the information provided by the applicant was not sufficiently detailed. The Tribunal ordered the following be added as disputed issues:

    i. Is the applicant entitled to an award under Ontario Regulation 664 because the respondent unreasonably withheld or delayed payments to the applicant?

    ii. Is the applicant entitled to costs from the respondent, pursuant to Rule 19.1 of the Common Rules of Practice and Procedure?

    iii. Is the respondent entitled to costs from the applicant, pursuant to Rule 19.1 of the Common Rules of Practice and Procedure?

e. On August 14, 2022, the applicant submitted a Notice of Motion for the respondent to calculate her whole person impairment. She also requested permission to record the hearing. On August 16, 2022, the applicant again sought an order for the respondent to determine her entitlement to housekeeping and home maintenance, and caregiver benefits. On August 30, 2022, the applicant requested an order for unpaid caregiver benefits, unpaid housekeeping and home maintenance benefits, unpaid case manager benefits, the determination of the applicant's disability and a recalculation of income replacement benefits. At a motion hearing dated August 31, 2022, the applicant withdrew the request to record the hearing. She also advised that the issues in dispute she wished to be added were already part of a different application. The Tribunal determined that it did not have jurisdiction to order the determination of the applicant's whole person impairment.

The Videoconference Hearing

[8] At the commencement of the hearing, the applicant affirmed her intention to represent herself, as she wanted to move forward with her claim. During her opening statement, she made references to issues that the Tribunal had previously declined to add to the claim, such as CAT determination. The applicant was reminded that the hearing was to determine her entitlement for accident benefits that were in dispute in relation to this claim, and that CAT determination was not one of them.

[9] All witnesses were called by the applicant. During her questioning, it quickly became apparent that her goal was to elicit some sort of acknowledgement of wrongdoing by the claim adjusters, the assessment company and/or the various medical/mental health professionals who assessed her. She did not call witnesses in support of her claim. On more than one occasion, the Tribunal cautioned the applicant about threatening the witnesses with "seeing them in court." According to the respondent, the applicant has initiated several lawsuits against it, and others.

[10] The applicant attempted to elicit information that there were assessment reports not provided to the assessing professionals, reports that were kept from her, or reports that were somehow altered by the assessment company. She offered no substantive evidence, and the answers of the witnesses provided no support for her theories. For example, at the start of the final hearing day, the applicant announced that during the previous night she discovered a document from a list the respondent provided at her request. She was emphatic that the document

"…would change the course of the entire hearing." She stated it was proof that documents were withheld from her. The respondent offered that the document title appeared to indicate that it was prepared by the applicant, but the applicant was adamant it was not hers. The respondent offered to investigate, located the document, and discovered that it was indeed a prior letter from the applicant to the insurer, requesting a reassessment. The applicant did not pursue the argument.

[11] The applicant bears the onus of proving, on a balance of probabilities, that any claimed benefits are reasonable and necessary. While the Tribunal and opposing counsel have a responsibility to assist a self-represented litigant where possible in order to achieve a fair hearing, that does not mean that the onus is lessened or that the Tribunal should make the applicant's case for them. Although the Tribunal attempted on several occasions to have the applicant focus her attention to the issues in dispute and the evidence and reasons why she believed she was entitled to various accident benefits, these attempts were largely unsuccessful.

ISSUES IN DISPUTE

[12] Given the application and the results of all case conferences and motion hearings, the following issues were identified as being in dispute:

a. Is the applicant entitled to an attendant care benefit ("ACB") in the amount of $2,972.44 per month for the period May 31, 2018 to date and ongoing, denied by the respondent June 12, 2018?

b. Is the applicant entitled to an ACB in the amount of $8,778.19 per month for the period January 7, 2019 to date and ongoing, denied by the respondent March 5, 2019?

c. Is the applicant entitled to an income replacement benefit ("IRB") in the amount of $375.90 per week for the period May 26, 2019 to date and ongoing, denied by the respondent May 22, 2019?

d. Is the applicant entitled to a medical benefit of $2,925.25 for occupational therapy services, denied by the respondent January 7, 2019?

e. Is the applicant entitled to a medical benefit in the amount of $4,389.65 for physiotherapy services, denied by the respondent September 27, 2018?

f. Is the applicant entitled to a medical benefit in the amount of $5,025.00 for physiotherapy services, denied by the respondent December 12, 2019?

g. Is the applicant entitled to a medical benefit in the amount of $4,688.00 for psychological services, denied by the respondent May 22, 2019?

h. Is the applicant entitled to a medical benefit in the amount of $4,914.40 for physiotherapy services, denied by the respondent July 19, 2018?

i. Is the applicant entitled to $2,460.00 for a physiatry examination, denied by the respondent July 22, 2019?

j. Is the applicant entitled to $2,460.00 for a psychological assessment, denied by the respondent July 10, 2019?

k. Is the applicant entitled to $2,128.51 for an attendant care assessment, denied by the respondent September 12, 2018?

l. Is the applicant entitled to $2,200.00 for a neurologist assessment, denied by the respondent September 11, 2018?

m. Is the applicant entitled to 2,200 for an orthopaedic assessment, denied by the respondent August 29, 2018?

n. Is the applicant entitled to $2,460.00 for an assessment, denied by the respondent July 19, 2018?

o. Is the applicant entitled to $2,200.00 for a chronic pain assessment, denied by the respondent June 14, 2018?

p. Is the applicant entitled to a medical benefit in the amount of $900.00 for occupational therapy services, denied by the respondent June 3, 2019?

q. Is the applicant entitled to an award under s. 10 of Ontario Regulation 664 because the respondent unreasonably withheld or delayed payments to the applicant?

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

s. Is the applicant entitled to costs from the respondent, pursuant to Rule 19.1 of the *Common Rules of Practice and Procedure*?

t. Is the respondent entitled to costs from the applicant, pursuant to Rule 19.1 of the *Common Rules of Practice and Procedure*?

RESULT

[13] The treatment plan recommending $2,925.25 for occupational therapy services was approved by the respondent on March 5, 2019 and was removed as an issue in dispute.

[14] The applicant is not entitled to any of the benefits in dispute, interest or costs.

ANALYSIS

Attendant Care Benefit for $2,972.44 per month

Attendant Care Benefit for $8,778.19 per month

[15] To establish entitlement to an ACB, the applicant bears the burden to prove that the ACB expenses are reasonable and necessary and are incurred pursuant to section 19(1) of the *Schedule*. Under section 3(7)(e)(iii), an expense is not considered incurred unless the person who provides a service did so in the course of his or her employment, occupation or employment in which he or she would ordinarily have been engaged but for the accident or sustained an economic loss as a result of providing the goods or services to the insured person.

[16] The applicant was granted ACBs in the amount of $2,972.44 per month in November 2017, following an attendant care assessment completed by Natalya Khramtsova, registered nurse, on November 5, 2017. In December 2018, she underwent an Occupational Therapy Assessment with Ayushi Dhingra, occupational therapist (“OT”), who also completed an Assessment of Attendant Care Needs form. Ms. Dhingra assessed the applicant’s attendant care needs at $8,778.19 per month. The applicant underwent an in-home OT IE assessment on February 13, 2019, when Christina Kovacic, OT, assessed that the applicant only required assistance for hair care and hygiene tasks in the bedroom and bathroom, amounting to $208.91 per month. The respondent informed the applicant that her ACB would be reduced proportionally.

[17] The applicant did not provide oral arguments as to why either benefit was reasonable and necessary. Her written submissions also lacked these details, predominantly providing a history of the actions taken by the respondent. She failed to call a professional witness to support her entitlement claim.

[18] The respondent observed that although the applicant was granted ACBs in November 2017, she has never incurred attendant care expenses. It submits that because ACBs are only payable when incurred, no payment is owing. The

respondent relies on the reports of the IE assessors identified above, that concluded that the benefit is not reasonable and necessary.

[19] Regarding the ACB for $2,972.44 per month the applicant was initially granted, the dispute is not an issue of entitlement but of payment. The respondent granted the applicant with entitlement to ACBs, up to the recommended amount, following the submission of the first attendant care assessment, in November 2017. However, no evidence was presented by the applicant of any professional service providers providing attendant care to her. Because ACBs can only be paid on evidence of incurred, no payment is owing. There is no dispute to be adjudicated regarding this treatment plan.

[20] Regarding the applicant's ongoing entitlement to ACBs, I find that the ACB recommended by Ms. Dhingra for $8,778.19 was excessive. Section 19(1) of the *Schedule* clearly states that attendant care benefits shall pay for all reasonable and necessary expenses that are incurred by, or on behalf of, the insured person as a result of the accident. From her report, I find it is clear that the assessor considered medical issues that were identified as pre-accident in nature and not as a result of the accident itself. One example is with the applicant's carpal-tunnel syndrome, which was already diagnosed by August 2017. There is no evidence to suggest that the condition was caused or impacted by the October 2017 accident, yet Ms. Dhingra clearly considered it when determining that the applicant required certain areas of assistance. I cannot conclude that her report accurately reflected the applicant's accident-related impairments and functionality.

[21] I prefer the report of Christina Kovacic, who assessed the applicant with $208.91 worth of ACBs per month. Properly, she appears to have only considered the applicant's accident-related impairments when assessing her functional limitations.

[22] The applicant's entitlement to ACBs is therefore maintained at $208.91 per month.

Income Replacement Benefit

[23] The applicant is not entitled to IRBs.

[24] To receive payment for an IRB under the *Schedule*, the applicant must first be (i) employed at the time of the accident and, as a result of and within 104 weeks after the accident, suffer a substantial inability to perform the essential tasks of that employment; or, (ii) not employed at the time of the accident but was

employed for at least 26 weeks during the 52 weeks before the accident and as a result of, and within 104 weeks after the accident, suffers a substantial inability to perform the essential tasks of the employment in which the insured person spent the most time during the 52 weeks before the accident (pre-104 week eligibility). An IRB may also be payable for the period an applicant suffers from a complete inability to engage in any employment or self-employment for which he or she is reasonably suited by education, training or experience (post-104-week eligibility). The applicant bears the burden of proving, on a balance of probabilities, that she meets the test.

[25] The applicant was collecting employment insurance at the time of the accident. As a result of an OCF-3 Disability Certificate, updated on November 29, 2017 by Dr. George Vavougios, the respondent authorized a pre-104 IRB in the amount of $375.00 per week. The respondent also sent a check for $6,657.19 to cover the preceding period of eligibility, commencing October 31, 2017. The respondent ceased payment of the benefit on May 22, 2019, following the receipt of assessment reports by Dr. Joel Jeffries on April 26, 2019 and Dr. Steven Baker on April 29, 2019.

[26] The applicant did not provide substantive arguments to support why she was entitled to IRBs after they were withdrawn by the respondent. She did not submit competing reports to challenge the findings of Dr. Jeffries or Dr. Baker. She did not call witnesses in support of her claim.

[27] The respondent submits that the decision to stop the benefit was reasonable, given the findings of the doctors, who both opined that the applicant did not have any ongoing impairments as a result of the subject accident that would prevent a return to work.

[28] Dr. Baker assessed the applicant on April 29, 2019, to address pre- and post-104 IRB eligibility. He determined that from a strictly musculoskeletal perspective, the applicant did not continue to suffer a substantial inability to perform the essential tasks of her pre-accident employment. He further noted that she did not have any restrictions that would preclude her employment in several occupations with limited-to-light physical demands, as her previous employment was. Dr. Baker also found that the applicant did not meet the post-104 IRB criterion of being completely unable to perform the essential tasks of her pre-accident employment.

[29] Dr. Jeffries assessed the applicant for pre- and post-104 IRBs on April 26, 2019. From a psychiatric standpoint, he found that the applicant had improved since he saw her the previous year, having done much better than he expected. In relation

to pre-104 IRB entitlement, he determined that she did not continue to suffer a substantial inability to perform the essential tasks of her employment. He further concluded that she did not meet the post-104 IRB criterion, which requires a complete inability to engage in any employment for which she was reasonably suited.

[30] The burden rests with the applicant to establish entitlement to IRBs. In the absence of competing reports or a cogent theory on entitlement, that burden has not been met. The applicant is not entitled to IRBs.

Medical/Rehabilitation Benefits

[31] The applicant is not entitled to the disputed treatment plans.

[32] To be entitled to the medical/rehabilitation treatment plans claimed, the applicant bears the onus to show that they are reasonable and necessary. To be reasonable and necessary, the goals of the treatment plan must be reasonable, the goals must be reasonably met, and the cost of the treatment plan must be reasonable. She did not meet her onus.

[33] In her written submission, the applicant generally alleges that the respondent was non-compliant with the *Schedule* in several areas but provided no details whatsoever. Her argument, in effect, was that the respondent was non-compliant because it denied the treatment plans. Her oral testimony and submissions were equally silent as to why she believed the treatment plans were reasonable and necessary. She did not call witnesses in support of her claim.

[34] The respondent submits that the applicant presented no evidence to establish entitlement to any of the disputed treatment plans. He states that without such evidence, she failed in her responsibility to demonstrate why they were reasonable and necessary.

[35] As stated, I am cognizant of the fact that the applicant is self-represented, and therefore, would not be as familiar as experienced counsel, with presenting evidence and arguments before an adjudicative tribunal. Where reasonable and not prejudicial to the respondent, she should be supported in navigating the hearing process to present her case.

[36] To that end, the Tribunal rescheduled events, in part, to allow the applicant to obtain legal representation. Unfortunately, she did not. The Tribunal also attempted to have her focus on the issues in dispute, to no avail. The majority of the applicant's attention and arguments were steadfastly focussed on

unsupported allegations against the respondent, the assessment company, the insurance medical assessors, and even her own prior lawyer. She failed to identify the correct legal test for each benefit.

[37] On review of the various Explanations of Benefits, I am unclear whether the alleged noncompliance violates s. 38 of the *Schedule*, the test in *Smith v Cooperators* or some other section of the *Schedule*. Without more detailed submissions on the alleged non-compliance, I cannot find in the applicant's favour that the respondent's denials were improper.

Interest

[38] No interest is payable.

[39] Interest is payable on any overdue payment of benefits pursuant to section 51 of the *Schedule*. The respondent authorized benefits for the applicant when there was sufficient information to establish entitlement. This does not constitute "overdue payments," as described in the *Schedule*.

Award

[40] The applicant is not entitled to an award.

[41] Section 10 of Regulation 664 provides that, if the Tribunal finds that an insurer has unreasonably withheld or delayed payment of benefits, the Tribunal may award a lump sum of up to 50 per cent of the amount in which the person was entitled.

[42] As I have found in that there are no payment of benefits or costs owing, there is no basis upon which to consider an award in this matter.

Costs

[43] Neither party is entitled to costs.

[44] Rule 19 of the Tribunal's *Common Rules*[1] states that where a party believes the other party has acted unreasonably, frivolously, vexatiously or in bad faith, the party may make a request to the Tribunal for costs. Rule 19.4 of the *Common Rules* requires the party seeking costs to provide submissions to set out the particulars of the respondent's conduct that are alleged to be unreasonable, frivolous, vexatious or in bad faith. A party may act in a manner that hinders the

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[1] Licence Appeal Tribunal, Animal Care Review Board, and Fire Safety Commission Common Rules of Practice and Procedure, Version I (October 2, 2017) as amended ("*Common Rules*")

efficiency of the Tribunal process but without the actions being unreasonable, vexatious or in bad faith the party's actions may not merit a costs award.

[45] The respondent argues that throughout the course of its claim, the applicant has acted in a manner that is frivolous and caused a huge amount of resources to be expended by the respondent and the Tribunal. He states that she submitted 11 Notices of Motion, with some dealing with the same issues. Respondent's counsel alleged he received more than 1000 emails from the applicant, compared to an average of ten from most applicants. The respondent further argues that the applicant's frivolous tactics have included issuing claims to the Superior Court against him, the respondent and all insurance examiners who dealt with her claim. The respondent seeks $1,000.00 per hearing day and $100 per Notice of Motion that had to be responded to.

[46] When asked for her submissions for why she believed she should be awarded costs from the respondent, the applicant simply stated that she asked for costs because the respondent did.

[47] First, the applicant has not produced any evidence or arguments to show that the respondent acted unreasonably, frivolously, vexatiously or in bad faith. Her request for costs is denied.

[48] Regarding the respondent's claim, I will acknowledge that the applicant's interactions with the respondent and the Tribunal were numerous and required a degree of resources to be expended that normally would not have been required. I will also acknowledge that the very rationale for the applicant's request for costs would appear to be frivolous. However, after four days of interacting with the applicant, I cannot conclude that there was any intent on her part to be unreasonable, frivolous, vexatious or act in bad faith.

[49] Throughout the hearing, I observed an individual who was passionate and steadfast in her belief that she was owed accident benefits by the respondent. I do not agree that the quantity of motions she submitted was done so frivolously, but simply reflected a self-represented applicant who was attempting to navigate the Tribunal's adjudicative processes to prepare her case. While experienced counsel may not have submitted as many motions, there is no specified limit to the number a party may submit.

[50] I am also not satisfied that the applicant's stated reasons for claiming costs had any intent of being frivolous. The issue started in an email from the respondent to the applicant, where he indicated that costs may be sought due to the applicant's interactions with him and the respondent. The applicant then simply responded

that she wanted the same. In this context, I cannot conclude that the applicant understood what costs entailed, apart from being a reimbursement to the victor for costs expended.

[51] To that end, I cannot conclude that awarding costs to the respondent would serve any purpose other than to financially punish the self-represented claimant for attempting to navigate her claim.

CONCLUSION

[52] For these reasons, I find that the applicant is not entitled to the claimed ACBs, IRB, treatment plans or an award. Neither party is entitled to costs. The application is dismissed.

Released: January 23, 2023

Terry Prowse
Adjudicator