



Citation: Rathakrishnan v. Aviva Insurance Company, 2023 ONLAT 19-009539/AABS

Licence Appeal Tribunal File Number: 19-009539/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:

Manjuladevi Rathakrishnan

Applicant

and

Aviva Insurance Company

Respondent

DECISION

ADJUDICATOR: Rachel Levitsky

APPEARANCES:

For the Applicant: Vismay Merja, Counsel

For the Respondent: Lauren Kolarek, Counsel

HEARD: By way of written submissions

OVERVIEW

- [1] Manjuladevi Rathakrishnan, the applicant, was involved in an automobile accident on November 21, 2016, and sought benefits pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010* (the “Schedule”). The applicant was denied benefits by the respondent, Aviva Insurance Company, and applied to the Licence Appeal Tribunal - Automobile Accident Benefits Service (the “Tribunal”) for resolution of the dispute.

ISSUES

- [2] The issues in dispute are:
- i. Is the applicant entitled to \$199.50 for physiotherapy proposed by Allied Physio and Rehab in a treatment plan dated February 13, 2017?
 - ii. Is the applicant entitled to \$1,197.50 for physiotherapy proposed by Allied Physio and Rehab in a treatment plan dated May 29, 2017?
 - iii. Is the applicant entitled to \$2,200 for a psychological assessment, proposed by Injury Management and Medical Assessment in a treatment plan dated April 15, 2020?
 - iv. Is the applicant entitled to \$2,200 for a chronic pain assessment, proposed by Injury Management and Medical Assessment in a treatment plan dated April 15, 2020?
 - v. Is the applicant entitled to \$2,095.28 for physical therapy, proposed by Carewell Physiotherapy and Rehab Inc. in a treatment plan dated August 13, 2021?
 - vi. Is the respondent liable to pay an award under s. 10 of Ontario Regulation 664 (“O. Reg. 664”) because it unreasonably withheld or delayed payments to the applicant?
 - vii. Is the applicant entitled to interest on any overdue payment of benefits?

RESULT

- [3] The applicant is statute barred from proceeding with the following claims:
- i. \$199.50 for a treatment plan for physiotherapy submitted by Allied Physio and Rehab on February 13, 2017.

- ii. \$1,197.50 for a treatment plan for physiotherapy submitted by Allied Physio and Rehab on May 29, 2017.

[4] The applicant is entitled to the following:

- i. \$2,200 for a psychological assessment, proposed by Injury Management and Medical Assessment in a treatment plan dated April 15, 2020.
- ii. Interest on any overdue payments pursuant to s. 51 of the *Schedule*.

[5] The applicant is not entitled to the following:

- i. \$2,200 for a chronic pain assessment, proposed by Injury Management and Medical Assessment in a treatment plan dated April 15, 2020.
- ii. \$2,095.28 for physical therapy, proposed by Carewell Physiotherapy and Rehab Inc. in a treatment plan dated August 13, 2021.
- iii. An award under s. 10 of O. Reg. 664.

PRELIMINARY ISSUE

- [6] Under s. 56 of the *Schedule*, an applicant has two years from the date an insurer refuses to pay an amount claimed to commence an application with respect to the denial of benefits that are refused.
- [7] The respondent submits that the applicant is barred from proceeding with her claim for issues (i) and (ii) in dispute. Issue (i) was denied on February 28, 2017, and issue (ii) was denied on June 13, 2017. The applicant commenced an application at the Tribunal on August 23, 2019, more than two years after each of the denials.
- [8] The applicant seeks relief from the expiry of the limitation period under s. 7 of the *Licence Appeal Tribunal Act, 1999* (the “*LAT Act*”). The applicant argues that the Tribunal has discretion to extend the limitation period, and submits that the Tribunal should exercise its discretion in this case.
- [9] The parties agree that the Tribunal has established that there are four factors to weigh when determining whether to grant an extension of time under s. 7 of the *LAT Act*: (a) the existence of a *bona fide* intention to appeal within the appeal period; (b) the length of the delay; (c) prejudice to the other party; and (d) the

merits of the appeal.¹ These factors are not strict elements that must be met, and the Tribunal has the discretion in how the factors are weighed.

- [10] I note that the applicant was previously barred from pursuing a claim for income replacement benefits, as she similarly applied to the Tribunal more than two years after the denial of that benefit.² Adjudicator Chakravarti found that the extension was not warranted. There are some differences with respect to the timing of the denial letters in the case before me, but it appears the applicant's arguments are relatively the same.

Bona Fide Intention

- [11] The applicant submits that she demonstrated an active intention to appeal her denials. She did this by retaining counsel, making repeated requests for her complete accident benefits file, and immediately requesting that the respondent re-open her claim after they advised her counsel that it had been "closed".
- [12] The respondent argues that retaining counsel does not inherently suggest an intention to dispute the specific benefits in dispute, and it is unclear how requesting a copy of the accident benefits file automatically connotes an intention to dispute.
- [13] The applicant advised the respondent that she retained counsel on June 26, 2017, and requested a complete copy of her file. She submits that she did not receive the file. She requested a copy of the file again on October 12, 2018, and received a copy of the file on CD. Her counsel wrote to the respondent again on June 21, 2019, advising that the password to access the file they had received in October wasn't working, and requesting a new copy. She followed up again on July 5, 2019, and received a copy of the file that day. She submits that after she received the file and was able to review it, the limitation period had already passed.
- [14] The respondent disagrees, stating that it had in fact provided the applicant's counsel with a copy of the accident benefits file on June 28, 2017. The respondent submits that it then provided a second copy of the file in October 2018. The applicant did not advise the respondent of the issue with the password until June 21, 2019, eight months later. The applicant also waited almost two months after receiving the third copy to file the application.

¹ *E.A. v. Aviva Insurance Company*, 2018 CanLII 112123 (ON LAT)

² *Rathakrishnan v. Aviva Insurance Company*, 2021 CanLII 30854 (ON LAT)

- [15] The applicant states that she did not receive a copy of the accident benefits file on June 28, 2017, as the respondent suggests. She argues that if she had received the file, she would not have made subsequent requests for it. I agree with the applicant that the evidence furnished by the respondent is insufficient to show that the file was sent to the applicant in June 2017. The respondent relies on an internal email showing that the file was prepared and sent from one department to another. That is not evidence that the file was actually sent to the applicant.
- [16] However, the applicant did receive a copy of the file in October 2018. No explanation has been provided as to why the applicant's counsel did not attempt to open the file at that time, or if they did, why they waited eight months to advise the respondent of the incorrect password. Further, no explanation has been provided as to why the applicant waited almost 16 months to request the complete file a second time. This laxity does not help the applicant in demonstrating an intention to appeal the denials promptly. I do not agree with the applicant's assertion that she was persistent in her attempts to obtain the complete file.
- [17] The applicant relies on *S.M. v. Motor Vehicle Accident Claims Fund*, 2017 CanLII 87161 (ON LAT), in stating that a person who has been denied benefits should have the opportunity to examine the decision maker's process and reasons for denying benefits, which are contained in the accident benefits file. The applicant attempted to rely on this argument before Adjudicator Chakravarti as well, but she found that case to be distinguishable. I agree. That case dealt with whether the Tribunal had jurisdiction to order the production of the respondent's file. While an insurer's file may contain relevant information to assist an insured person in disputing a denial, it is not necessarily integral to being able to submit application to the Tribunal. More evidence is required as to why the applicant required the file in order to make an application.
- [18] The denial letters were delivered to the applicant directly, prior to her retaining counsel. She does not argue that she did not receive the letters, or that there was some reason she could not review them with or without the assistance of counsel. I agree with the respondent that it is not compelling to argue that the only reason for the delay was that the insurer did not provide a complete copy of the file to new counsel in a timely manner. The applicant must provide a reason why the denial dates could not have been established by reviewing the documents received. She has not done so.

- [19] Instead, the applicant argues that she requested her file so that she could review the respondent's decision making process and reasons for denying her medical benefits. In light of that submission, it appears that the applicant was, in fact, aware that the benefits had been denied. I see no reason why the applicant could not have at least submitted an application to the Tribunal prior to the limitation period elapsing.
- [20] I also do not find that simply requesting that her file be re-opened demonstrates an intention to dispute the denials in question. All that suggests is an intention to continue to claim accident benefits generally, not necessarily dispute any denials.
- [21] I find that there was no *bona fide* intention to appeal the treatment plans in dispute.

The Length of the Delay and Prejudice to the Respondent

- [22] The applicant submits that the delay in disputing the denials was only 176 and 27 calendar days, respectively. The application was commenced 49 days after receiving the accident benefits file. She argues that there is only a slight delay, and it has not produced any resultant prejudice for the respondent that outweighs her prejudice in her entitlement to the denied treatment plans. The respondent submits that the delays remain unexplained, and that s. 7 of the *LAT Act* is not a safety net for litigants who sleep on their rights or who do not move expeditiously to advance their claims.
- [23] I do find that the delay in disputing the denials was not an insignificant amount of time, especially as no explanation has been provided as to why the applicant waited almost two months to apply to the Tribunal after receiving the complete file. However, the respondent has not advanced any arguments or evidence to demonstrate that it has actually been prejudiced by the applicant's delay. While I agree that there may be prejudice inherent when limitation periods are undermined, without any other evidence, I find that any prejudice in this case is minimal. I accordingly find that the length of the delay has had a minimal impact on the respondent.

Merits of the Case

- [24] The parties disagree as to whether the treatment plans for physiotherapy are reasonable and necessary. The applicant submits, however, that the Tribunal is not required to decide whether the applicant will necessarily succeed on her application, but must decide whether there is a live issue for a hearing.

- [25] As indicated below, an analysis is required in order to determine whether physiotherapy is reasonable and necessary. It cannot be said that the applicant's case with respect to these treatment plans is meritless.

Tribunal's Discretion

- [26] I find that on balance, the analysis favours the respondent. The applicant has not provided a compelling reason as to why the extension of time should be granted, or that she had a *bona fide* intention to dispute the denials. The evidence and the applicant's own submissions suggest that she knew about the denials prior to receiving the complete accident benefits file. Even after receiving the file, the applicant waited eight months to advise the respondent that there was an issue with accessing it, and waited almost two months after being able to access the file before applying to the Tribunal. Having considered all of the factors, I decline to exercise the Tribunal's discretion under s. 7 of the *LAT Act*.

ANALYSIS ON SUBSTANTIVE ISSUES

Is the applicant entitled to \$2,200 for a psychological assessment?

- [27] To receive payment for a treatment and assessment plan under s. 15 and 16 of the *Schedule*, the applicant bears the burden of demonstrating on a balance of probabilities that the benefit is reasonable and necessary as a result of the accident. To do so, the applicant should identify the goals of treatment, how the goals would be met to a reasonable degree and that the overall costs of achieving them are reasonable.
- [28] I find that the applicant is entitled to a psychological assessment.
- [29] The applicant was diagnosed with Adjustment Disorder with Mixed Anxiety and Depressed Mood by a s. 44 assessor, Dr. Marino, in 2017. Dr. Marino found that the applicant's condition was at least partially attributable to the accident, and recommended psychological treatment. In response to the applicant's request for her own psychological assessment, the respondent sent her for another s. 44 assessment, this time with Dr. Ladak in 2021. Dr. Ladak diagnosed the applicant with Adjustment Disorder with Depressed Mood, but stated that her current symptoms were not as a result of the accident. She did not comment on Dr. Marino's opinion with respect to causation.
- [30] The applicant complained of stress, anxiety, and depression to her family physician, Dr. Singh, on multiple occasions throughout 2017, once in 2018, and

once in 2019. There are no further records from Dr. Singh that mention psychological symptoms.

- [31] Appended to the OCF-18 in question were the results of a pre-screening interview by Umair Malik, registered psychotherapist. Ms. Malik indicated that the applicant was experiencing a number of psychological symptoms including fear in a vehicle, sadness, depression, stress, flashbacks, nightmares, hopelessness, anger, and irritability. She noted that the applicant was motivated to get better, and explained that a thorough psychological assessment was warranted to understand the applicant's current psychological status, understand her background, and assist with treatment planning.
- [32] The applicant submits that in order to determine whether an assessment is reasonable and necessary, there must be some evidence that the applicant might have the condition the assessment will investigate. She submits that the purpose of the proposed assessment was to seek confirmation of Dr. Marino's diagnosis from her own assessor, and to know what her assessor's recommendations for treatment would be. She argues that if the insurer felt it was reasonable and necessary to have her assessed by two different assessors, her own psychological assessment would be reasonable and necessary.
- [33] The respondent submits that the applicant has not provided compelling evidence to demonstrate that a psychological assessment is reasonable and necessary, especially as the applicant did not mention any psychological difficulties to Dr. Singh past January 2019. The respondent relies on Dr. Ladak's opinion that the applicant's symptoms are not attributable to the accident. The respondent also argues that the Tribunal should give more weight to Dr. Ladak's opinion than the OCF-18 completed by Ms. Wagner, psychological associate, as Dr. Ladak's opinion is more consistent with the treatment records.
- [34] I agree that the treatment records are sparse, particularly past 2019, and that Dr. Ladak's report is of course more thorough than a pre-screening report appended to an OCF-18. However, Dr. Ladak diagnosed a similar condition as Dr. Marino and yet came to the opposite conclusion with respect to causation, without any explanation as to the discrepancy. There appear to be questions regarding the applicant's psychological condition that merit further assessment.
- [35] Given the opinion of Dr. Marino in 2017, the pre-screening report of Ms. Malik, and the diagnosis provided by Dr. Ladak, I find that it is reasonable and necessary for the applicant to be able to be assessed by Ms. Wagner in order to determine what, if any, treatment she requires as a result of the accident. While there is a question as to whether the applicant's psychological difficulties still

stem at least in part from the accident, I find that it is reasonable for the applicant to explore whether that is the case. Further, clearly the respondent felt that an assessment was reasonable and necessary as it was content to pay for two with its own chosen assessors. It cannot be said that an assessment is only warranted when completed by an insurer's chosen assessor.

Is the applicant entitled to \$2,200 for a chronic pain assessment?

- [36] I find that the applicant has not proven on a balance of probabilities that a chronic pain assessment is reasonable and necessary.
- [37] An OCF-18 was submitted on April 15, 2020 for a chronic pain assessment with Dr. Getahun, orthopaedic surgeon. In determining whether the assessment is reasonable and necessary, I must consider whether it is reasonably possible that the applicant suffers from chronic pain or chronic pain syndrome.³ The onus is on the applicant to prove that possibility.
- [38] The applicant largely relies on the records of Dr. Singh, who makes specific reference to "chronic pain" and "chronic pain syndrome" in his records throughout 2017. However, past 2017, Dr. Singh no longer mentions chronic pain. The only potentially accident-related physical complaints that applicant made in 2018 were intermittent headaches for a few days in July. In 2019, there are two records of intermittent headaches, pain for 2 days as a result of lifting more weights than usual, and an onset of 4 days of back pain. In January 2020 the applicant saw Dr. Singh and complained of low back, upper back, shoulder, and left leg pain, however no further referrals, diagnoses, or recommendations were made, and the accident was not mentioned. Finally, on July 30, 2020, the applicant called Dr. Singh requesting a referral for massage therapy. Dr. Singh requested that she book a further appointment to discuss, but there is no indication that she ever did. Although Dr. Singh's records end in June 2021, there is a separate document from Dr. Singh's office dated August 18, 2021 which refers the applicant to Carewell Clinics for a rehabilitation program. The referral note states "MVA: generalized pain, neck, low back, shoulders".
- [39] The applicant also relies on the right shoulder ultrasound results from February 2019 which show moderate supraspinatus tendinosis, mild subscapularis tendinosis, and mild biceps tenosynovitis. There are no further records regarding these findings. It is unclear who sent the applicant for this ultrasound or why, and there are no corresponding records from Dr. Singh. I do not find that this one

³ *R.V. v. Aviva General Insurance*, 2019 CanLII 94032 (ON LAT) at para. 49

note is overly helpful in determining the applicant's condition at the time the ultrasound was completed, nor whether the condition was accident-related.

- [40] The applicant was also seen by Dr. Wong, physiatrist, for carpal tunnel syndrome before and after the accident. In a general list of her "past history" in 2019, he writes "chronic back pain", however he does not treat her for this condition or elaborate further. It is impossible to determine if he was referring to injuries sustained in the 2016 accident. It is also not clear why, if the applicant was suffering from chronic pain, this would not have been discussed with Dr. Wong further, or why Dr. Singh did not refer her to Dr. Wong or another specialist for that issue as well.
- [41] The OCF-18 for the chronic pain assessment included a pre-screening report, however this was completed by Umair Malik, a psychotherapist. She does not have the credentials to comment on the applicant's pain or physical limitations, and an OCF-18 is not sufficient in itself without supporting medical evidence. I therefore assign this document little weight.
- [42] I have little doubt that the applicant sustained physical injuries in the accident. Although the applicant had been diagnosed with fibromyalgia prior to the accident, there are no details regarding the extent of this condition or her symptoms. There is indication that the applicant was receiving physical therapy before the accident, took similar pain medications before and after the accident, and had modified her household chores as a result of a motor vehicle accident in 2010. However, based on the frequency and consistency of her pain complaints to Dr. Singh in 2017, and a lack of complaints in the couple of years prior, it appears that her symptoms at least at that time were as a result of the accident.
- [43] It does also appear, however, that the applicant's accident-related pain symptoms improved over time. Where her symptoms are mentioned to Dr. Singh after 2017, they are mentioned sporadically and are described as intermittent or only lasting a number of days. In the treatment records of Allied Physiotherapy and Rehab Inc. from February and March 2017, it appears that the applicant's symptoms were improving, and her pain was on and off with less frequency.
- [44] The respondent relies on the s. 44 report of Dr. Heitzner, physiatrist, of November 11, 2021, who stated that a chronic pain assessment was not reasonable or necessary. He opined that the accident aggravated the applicant's pre-existing injuries, but that her accident-related injuries had resolved. Dr. Heitzner found that the applicant did have some pain and mild decreased range of motion during his examination, but also stated that with distraction, similar pain responses could not be obtained.

- [45] The applicant submits that Dr. Heitzner failed to consider the American Medical Association (AMA) Guides 6th Edition criteria for chronic pain syndrome, but also the fact that she continues to suffer from impairments and pain is enough to warrant a chronic pain assessment.
- [46] While I agree that Dr. Heitzner did not conduct a chronic pain assessment, the purpose was not to determine whether the applicant suffers from chronic pain syndrome. His task was to determine whether a chronic pain assessment and further physiotherapy was reasonable and necessary. I do not find that Dr. Heitzner's report is determinative of this issue, however in the absence of other recent medical documentation, his report does provide information regarding the applicant's condition which I find helpful.
- [47] I disagree with the applicant's assertion that since Dr. Heitzner documented pain and limitations during his assessment, that automatically entitles her to a chronic pain assessment. Firstly, Dr. Heitzner found that the applicant's pain was inconsistent during her physical examination. Secondly, it is difficult to determine whether the symptoms she is experiencing now are the same as she was experiencing prior to the accident. The medications and treatment she was taking prior to the accident was largely the same as after the accident. The applicant also told Dr. Heitzner that after her 2010 accident, her symptoms were 80% better but she still had symptoms and limitations with housekeeping and cooking.
- [48] It is not enough for the applicant to say in her submissions that she has been experiencing pain since the 2016 accident, and therefore she has met her onus in proving that a chronic pain assessment is warranted. I cannot determine, based on the evidence before me, whether at the time the OCF-18 was submitted, the applicant was still suffering from accident-related pain, the level or frequency of her pain, or whether she had any functional difficulties as a result. I do not find that the applicant has met her onus in proving that there is a possibility that she still suffers from chronic pain such that an assessment is reasonable and necessary.

Is the applicant entitled to \$2,095.28 for physical therapy?

- [49] I find that applicant has not proven on a balance of probabilities that the treatment plan for further physical therapy, dated August 13, 2021, is reasonable and necessary.
- [50] The applicant submits that Dr. Singh recommended physiotherapy nine times since the accident. This is not accurate. Firstly, prior to the 2021 referral note, Dr. Singh had recommended physiotherapy six times, and not past August 10, 2017.

Massage therapy was recommended on October 29, 2019 as a result of a flare-up of low back pain. On July 30, 2020, the applicant told Dr. Singh that she had finished physiotherapy, and wanted a massage referral sent to Carewell. At that time, Dr. Singh queried who gave her the referral for physiotherapy, and requested that she call and book an appointment with him for the next week. There is no record of that appointment ever happening.

- [51] In my view, the only compelling evidence that further physical therapy may be warranted is the referral note from Dr. Singh's office to Carewell on August 18, 2021. However, this note only refers vaguely to an "MVA", and doesn't state which accident she is receiving treatment for.
- [52] The OCF-18, submitted by physiotherapist Sarika Jha, notes that the applicant had an accident in 2010, and as a result she received rehab periodically every year. When asked whether the applicant received treatment for her pre-existing issues in the past year, Ms. Jha wrote: "she got rehab service for the first accident", and "she continued rehab services since 2014 from Allied Physiotherapy facility for multiple MSK issues".
- [53] I find that the applicant has failed to provide evidence that her physical condition and need for physical therapy as of 2021 was causally related to the 2016 accident. In fact, the applicant admits this in her reply submissions. She states that without a chronic pain assessment, she has "no way to prove her current complaints are a result of the subject accident." She further states that she should be given an opportunity to attend the assessment with Dr. Getahun "to determine what her needs are for physiotherapy". She effectively admits that she does not know whether she should be attending physiotherapy.
- [54] The applicant cannot blame the respondent for refusing to fund the assessment with Dr. Getahun, given my reasons above. Further, there is no guarantee that Dr. Getahun would have attributed her current difficulties to this accident, or that he would have recommended further physical therapy.
- [55] In any event, it is the applicant's burden to prove that further physical therapy is reasonable and necessary. I do not agree that there is "no way" for her to prove that the therapy is warranted without a chronic pain assessment. In 2017, there was medical evidence that physiotherapy was warranted. That is not the case for 2021. I do not find that Dr. Singh's referral from 2021, on its own, tips the scales in favour of the applicant. It is possible that the applicant is deriving a benefit from therapy, but she has not provided physical therapy records since 2017, despite the respondent's request for them, and has not explained why she could

not obtain them. Whether physical therapy is helping the applicant with injuries sustained in the 2016 accident is a question that remains to be answered.

Interest

- [56] Interest applies on the payment of any overdue benefits pursuant to s. 51 of the *Schedule*. Interest is payable on the psychological assessment, if incurred.

Award

- [57] Under s. 10 of O. Reg. 664, the applicant may be entitled to an award of an amount up to 50% of the benefits and interest owed to her if I find that the respondent unreasonably withheld or delayed payments. I find that the applicant has failed to show that this is the case.
- [58] The applicant does not make any submissions with respect to her claim for an award. The respondent submits that the applicant has never provided any particulars of her claim for an award, and thus does not know the case it needs to meet. I find that in the absence of any submissions or evidence with respect to the insurer unreasonably withholding or delaying the benefit owing, the applicant has not met her burden in proving that she is entitled to an award.

ORDER

- [59] The applicant is statute barred from proceeding with the following claims:
- i. \$199.50 for a treatment plan for physiotherapy submitted by Allied Physio and Rehab on February 13, 2017.
 - ii. \$1,197.50 for a treatment plan for physiotherapy submitted by Allied Physio and Rehab on May 29, 2017.
- [60] The applicant is entitled to the following:
- iii. \$2,200 for a psychological assessment, proposed by Injury Management and Medical Assessment in a treatment plan dated April 15, 2020.
 - iv. Interest on any overdue payments pursuant to s. 51 of the *Schedule*.
- [61] The applicant is not entitled to the following:
- v. \$2,200 for a chronic pain assessment, proposed by Injury Management and Medical Assessment in a treatment plan dated April 15, 2020.

- vi. \$2,095.28 for physical therapy, proposed by Carewell Physiotherapy and Rehab Inc. in a treatment plan dated August 13, 2021.
- vii. An award under s. 10 of O. Reg. 664.

Released: June 8, 2023



Rachel Levitsky
Adjudicator