Citation: Alkhatlan v. Aviva Insurance Company of Canada, 2025 ONLAT 23-010231/AABS

Licence Appeal Tribunal File Number: 23-010231/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:

Badreyah Alkhatlan

Applicant

and

Aviva Insurance Company of Canada

Respondent

DECISION

VICE-CHAIR: **Trina Morissette, Vice-Chair**

APPEARANCES:

For the Applicant: Avneet Kaur, Counsel

For the Respondent: Sonya Katrycz, Counsel

HEARD: In Writing

OVERVIEW

[1] Badreyah Alkhatlan, the applicant, was involved in an automobile accident on January 31, 2023, and sought benefits pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010 (including amendments effective June 1, 2016)* (the *Schedule*). The applicant was denied benefits by the respondent, Aviva Insurance Company of Canada, and applied to the Licence Appeal Tribunal (the Tribunal) for resolution of the dispute.

ISSUES

[2] The issues in dispute are:

i. Is the respondent liable to pay an award under section 10 of Regulation 664 because it unreasonably withheld or delayed payments to the applicant?

ii. Is the respondent entitled to costs on this hearing?

RESULT

[3] The respondent is not liable to pay an award.

[4] The respondent is not entitled to costs.

BACKGROUND

[5] The applicant is a 66-year-old woman who was involved in a pedestrian-vehicle collision on January 31, 2023. As a result of the accident, she sustained a left tibial plateau fracture, an associated fracture of the left fibular head, pain and discomfort in her neck and back, and pain and discomfort on the left side of her body, including the hip and thigh. The applicant does not have OHIP coverage.

[6] The applicant initially claimed entitlement to monthly attendant care benefits (ACB), five treatment plans, interest, and an award. At a case conference held March 6, 2024, the respondent raised a preliminary issue being whether the applicant was barred from proceeding to a hearing for all of the benefits claimed because the applicant had reached the limit of non-catastrophic (non-CAT) injury category of payment and no catastrophic (CAT) injury application had been filed. In the Case Conference Report and Order issued March 15, 2024, the preliminary issue was added to the application and ordered to be heard prior to the substantive issues.

[7] A Preliminary Issue Hearing Decision and Order (PIH Decision and Order) was issued May 8, 2024. The Tribunal found that with the non-CAT limit exhausted, it was premature to make any findings about the applicant's entitlement to the disputed benefits and interest. The Tribunal concluded that the applicant may proceed to the hearing with respect to her claim for an award but dismissed the other issues in dispute, without prejudice, to the applicant bringing a future application where CAT was either accepted or in dispute.

[8] The PIH Decision and Order also addressed the respondent's request for costs. The Tribunal concluded that it did not find that the applicant's conduct should attract an award for costs. The Tribunal stated that it accepted the applicant's belief that she was pursuing a genuine claim for benefits, although prematurely.

[9] The claim for an award proceeded to this written hearing.

ANALYSIS

Is the respondent liable to pay an award because it unreasonably withheld or delayed payments to the applicant?

[10] I find that the respondent is not liable to pay an award.

[11] Regulation 664, R.R.O. 1990 states that if the Tribunal finds that an insurer has unreasonably withheld or delayed payments, the Tribunal, in addition to awarding the benefits and interest to which an insured person is entitled, may award a lump sum of up to 50 percent 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 two percent per month, compounded monthly, from the time the benefits first became payable under the *Schedule*.

[12] The Tribunal has established that an award should be granted only where there was unreasonable behaviour by an insurer in withholding or delaying payments which can be seen as excessive, imprudent, stubborn, inflexible, unyielding or immoderate (*Applicant v. Portage La Prairie Mutual Insurance Company*, 2019 CanLII 101649 (ON LAT), at para. 72).

[13] The applicant submits that the respondent unreasonably withheld or delayed payments and failed to adjust the file in good faith throughout the claims process. The entirety of her submissions rely on her entitlement to benefits based on sections 38(8) and 42(6) of the *Schedule* and she argues that upon receipt of the treatment plan, the respondent failed to provide clear medical reasons pursuant

to section 38(8) for its denial. As per section 42(6), the applicant argues that the attendant care invoices should have been paid within 10 business days of receiving the attendant care report.

[14] The applicant submits that the respondent's arbitrary and unjustifiable denial of her attendant care benefits and treatment plan constitutes bad faith. The respondent not only ignored the timelines and requirements under the *Schedule* but also withheld payment of benefits that had already been approved causing significant financial strain. She relies on the decisions in *16-002779 v. BelairDirect Insurance*, 2017 CanLII 70688 (ON LAT) and *Applicant v. Portage La Prairie Mutual Insurance Company*, 2019 CanLII 101649 (ON LAT) to support her position.

[15] The respondent submits there was no violation of timelines or payment obligations under the *Schedule* and relies on *16-002346 v. Uninfund Assurance Company*, 2017 CanLII 81583 (ON LAT) to submit that an improper denial of a treatment plan is not a sufficient basis on which to grant an award. It argues that the applicant's submissions are based on the alleged denials of the ACB and the treatment plan. The respondent states that the claim for a treatment plan for physiotherapy services was withdrawn by the applicant at the case conference because the respondent approved it on August 25, 2023. Regarding the ACB, the respondent submits that the applicant is disputing entitlement to a benefit that cannot be paid under the policy. It explains that she claimed (in the initial application) $7,584.50 per month which is beyond the limit of entitlement allowed by the *Schedule*, being $3,000.00 per month.

[16] I will now turn to a consideration of each of the grounds for an award argued by the applicant.

Did the respondent fail to comply with section 38(8) of the* Schedule*?

[17] I find that the denial of the treatment plan is compliant with section 38(8) of the *Schedule* and is not grounds for an award.

[18] Sections 38(8) and 38(11) of the *Schedule* set out strict notice requirements for insurers responding to treatment plans and specific consequences if they fail to comply. Section 38(8) requires an insurer to inform an insured person within ten business days after it receives an OCF-18 which goods, services, assessments, and/or examinations it agrees to pay for, and which it does not, as well as the medical and other reasons why it considered any goods and services to not be reasonable and necessary.

[19] If any insurer fails to comply with its obligations under section 38(8), the following consequences set out in section 38(11) of the *Schedule* are triggered:

> (a) The insurer is prohibited from taking the position that the insured person has an impairment to which the Minor Injury Guideline applies.
>
> (b) 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).

[20] It is well-settled that the insurer's "medical and any other reasons" should include specific details about the insured's condition forming the basis for the insurer's decision or, alternatively, identify information about the insured's condition that the insurer does not have but requires. According to *Smith v. Co-operators General Insurance Co*, 2002 SCC 30 (*Smith*), the refusal to pay the benefit must contain straightforward and clear language directed towards an unsophisticated person and must provide valid or other reasons for the denial. *Smith* requires a denial notice to be as specific and accessible as possible to ensure that there is no ambiguity in what the reasons mean when read by an unsophisticated person.

[21] The applicant submits that the respondent's Explanation of Benefits (EOB) for the treatment plan for physiotherapy treatment and devices failed to provide clear medical reasons for its denial. The respondent did not provide responding submissions specific to this argument.

[22] In an EOB dated June 28, 2023, the respondent denied the treatment plan (dated June 7, 2023 and submitted June 16, 2023) by Total Wellness Clinic for physiotherapy treatment and devices in the full amount of $9,794.74. The respondent states:

> Please note, the policy limit for medical and rehabilitation benefits, including attendant care, on your policy is $65,000. Currently, [the respondent] has paid $4,069.04. However, we received invoices from your treatment at Trillium Health Partners that total $141,206.73. Therefore, the treatment proposed will exceed your policy limits. […] As the proposed treatment is above your policy limits we are unable to approve the treatment plan at this time.

[23] I find that the denial properly references the treatment plan and was provided within the 10-business day timeframe stipulated by the *Schedule*. I acknowledge

that the respondent does not reference any medical reasons, but I find that the other reasons provided (e.g., that the request for benefits submitted exceed the non-CAT limit of $65,000.00) satisfy the requirement to provide "all other reasons" of section 38(8). I also find that it would have been improper for the respondent to add that the applicant had not been designated CAT – a medical reason – and to request documentation that supports that she is, as two years had not yet elapsed since the accident and the applicant was not yet eligible to file an OCF-19.

[24] I therefore find the reasons provided in the EOB to be valid, clear and straightforward. The denial is valid.

[25] Had I found the denial was deficient, this would raise an important question of statutory interpretation. Section 38(11)1 of the *Schedule* states that an insurer cannot rely on the Minor Injury Guideline (MIG) limit if found that the denial is deficient. The applicant has not pointed me to any binding caselaw or legislative authority which would show that the Tribunal has jurisdiction to order payment of a treatment plan pursuant to section 38(8) when the non-CAT limit of $65,000.00 has been exhausted. In any event, having found that the denial is valid, I do not need to address the question of the Tribunal's jurisdiction in this matter.

Did the respondent unreasonably withhold or delay payment of the treatment plan?

[26] The respondent did not unreasonably withhold or delay payment of the treatment plan.

[27] Both parties agree that the treatment plan referenced above was subsequently approved. The applicant argues that, at the time the treatment plan was submitted, the respondent had not paid the hospital invoices and therefore should not have denied and/or delayed the approval of the treatment plan as the $65,000.00 non-CAT limit had not yet been exhausted. The respondent submitted that the applicant was being disingenuous in her submissions.

[28] Both parties submitted correspondence with their submissions and it is only after reviewing all of the correspondence that a full picture of the events was made clear. I summarize these communications as follows.

[29] Prior to the applicant submitting the treatment plan, the respondent had received hospital invoices totalling over $100,000.00. Since the applicant did not have OHIP coverage, the respondent requested that the applicant confirm whether she

had additional coverage, such as travel insurance, that could cover part of the costs.

[30] On August 18, 2023 – having not received a response regarding additional coverage – the respondent communicated with the applicant. The respondent advised the applicant that it would agree to reconsider the denial of the treatment plan and would allocate the balance remaining of the non-CAT limit to the hospital invoices. It asked the applicant to confirm this course of action. The respondent did not hear from the applicant until August 25, 2023.

[31] On August 25, 2023, the applicant contacted the respondent inquiring whether the hospital invoices were paid and seeking clarification on how the denial of the treatment plan could be based on policy limits being exhausted when no payment had actually been made. The respondent referenced the August 18, 2023 email and accepted the applicant's August 25, 2023 email as confirmation that she agreed with the course of action proposed, which was to approve the treatment plan and use the remaining benefits to pay the hospital invoices. The treatment plan was approved.

[32] I find that the respondent did not unreasonably withhold or delay payment of the treatment plan. At the time the treatment plan was submitted, it had received invoices over and above the non-CAT limit and denied the request with reasons. Despite the denial, and as it was still awaiting information (additional coverage) from the applicant to properly adjust the claim, it showed flexibility by contacting the applicant on August 18, 2023 and offering to reconsider its denial. The respondent did not receive a response from the applicant until August 25, 2023, at which time, the treatment plan was approved.

Did the respondent act in bad faith, unreasonably withhold and/or delay the attendant care benefits?

[33] There is insufficient evidence to conclude that the respondent acted in bad faith, unreasonably withheld or delayed payment of the ACB.

[34] The applicant submits that the respondent failed to pay for any ACB within the timeline mandated by section 42(6) of the *Schedule* despite having approved the applicant's entitlement. Six months after submitting the ACB invoices, the applicant argues that she contacted the respondent and demanded immediate payment of the outstanding invoices but all she received was a standard response stating that "the new adjuster would review the file".

[35] The respondent submits that the applicant's submissions are a misrepresentation of the facts. The respondent argues that all the applicant submitted was an invoice for services rendered from May 1 to 14, 2023, three OCF-6 forms which did not correspond to the invoice (the OCF-6 forms were dated March 31, 2023, April 11, 2023 and May 15, 2023) and a "personal care form" for the May 2 to 14, 2023 period. The sole invoice submitted was for two weeks worth of treatment rendered between May 1 to 14, 2023 at a total cost of $2,966.25. The respondent argues that the invoice and "personal care form" reflected that the personal care worker (PSW) provided services to the applicant at six hours per day, but the quantum sought (nearly $3,000.00 over just two weeks) far exceeded the cost of six hours of care per day. The respondent concludes that there was a huge disjunct between the services rendered and the invoiced amount and it sought clarification/additional information from the applicant.

[36] I summarize the events relating to the ACB as follows.

[37] On March 10, 2023, the applicant submitted an attendant care assessment and Form 1 for ACB in the amount of $10,584.05 per month.

[38] On March 31, 2023, the respondent partially approved the ACB request in the amount of $3,000.00 per month pursuant to the *Schedule*.

[39] Upon receipt of the "invoices" submitted by the applicant, the respondent provided an EOB dated May 31, 2023 in which it explained the discrepancies in the information provided and advised the applicant that, to issue payment for the ACB invoice, it required:

i. Invoices for the March and April ACB incurred;

ii. Personal care forms for the other dates the PSW provided care, indicating the dates, times and services that were provided; and

iii. The PSW's certification.

[40] On September 19, 2023, the applicant resubmitted the same "invoices" to the respondent and noted that they remained unpaid. In response, the respondent advised the applicant "[p]lease be advised [another adjuster] is the adjuster handling this claim."

[41] No further correspondence relating to the ACB was submitted by either party.

[42] The applicant submits that no further response was provided, none of the invoices were paid and to date, the PSW has not been compensated for the

services rendered, nor has the applicant received an explanation for the lack of payment.

[43] The respondent submits that it provided a clear explanation to the applicant in its EOB of May 31, 2023, and requested reasonably necessary information to which the applicant never responded. Since then, the applicant submitted her invoice for hospital services which exhausted the non-CAT limit. It submits that no more ACB is payable unless the applicant is deemed CAT.

[44] I note that by the time the applicant sent her correspondence of September 19, 2023 to the respondent, the issue regarding payment of the treatment plan with the remaining balance of the non-CAT limit being put towards the hospital invoices had been communicated (on August 25, 2023).

[45] Evidence submitted indicates that the applicant submitted an OCF-6 on November 9, 2023, seeking reimbursement for $455,530.06 owed to the hospital. In an EOB dated November 9, 2023, the respondent partially approved the OCF-6 in the amount of $48,607.24, being the remainder of the non-CAT limit of $65,000.00.

[46] As per the PIH Decision and Order dated May 8, 2024, entitlement to the ACB is not currently before me. I am to determine only whether the respondent unreasonably withheld or delayed payment of the ACB to the applicant for the purposes of determining whether the respondent is liable to pay an award.

[47] It is not possible to determine whether the respondent is liable to pay an award in relation to the ACB without first determining whether the applicant is entitled to the ACB. I acknowledge that the respondent partially approved entitlement in the amount of $3,000.00 per month but it was only after the non-CAT limit was exhausted did the applicant submit the “invoices”. Without a finding that the applicant was entitled to the amounts she initially submitted on March 31, 2023, I cannot conclude that the respondent unreasonably withheld or delayed any payment.

[48] As such, and further to my finding regarding the treatment plan above, I find on a balance of probabilities that the respondent is not liable to pay an award. The evidence before me does not support that payment of a benefit was improperly withheld.

The respondent's request to add costs to the issues in dispute

[49] In its responding submissions, the respondent sought costs on this hearing in the amount of $1,000.00.

[50] Rule 19.1 of the *Licence Appeal Tribunal Rules, 2023* provides that a party may make a request to the Tribunal for its costs where a party believes that another party in a proceeding has acted unreasonably, frivolously, vexatiously, or in bad faith. Rule 19.2 allows a request for costs to be made any time before a decision is released.

[51] I find that the respondent was not out of time to request to add the issue of costs as this decision had not yet been released. Also, adding the issue of costs through its responding submissions ensures procedural fairness as it allows sufficient time for the applicant to respond through the filing of her reply submissions.

[52] The request for costs is therefore properly before me.

[53] Rule 19.5 sets out the relevant factors that the Tribunal must consider in deciding whether to award costs and the amount of costs to be ordered. These factors include: the seriousness of the misconduct; whether the conduct was in breach of a direction or order issued by the Tribunal; whether or not a party's behaviour interfered with the Tribunal's ability to carry out a fair, efficient, and effective process; prejudice to other parties; and the potential impact an order for costs would have on individuals accessing the Tribunal system.

[54] The respondent submits that the applicant filed her application with the Tribunal with no chance of success. The preliminary issue hearing vacated all substantive issues in dispute but the applicant, nevertheless, chose to proceed to a hearing on the stand-alone issue of the award. The respondent argues that the applicant has, time and again, demonstrated flagrant, wanton disregard for intellectual honesty, procedural fairness, and for the resources of both the parties and the Tribunal. It submits that a cost order is appropriate.

[55] The applicant did not file reply submissions.

[56] All conduct that occurred prior to this written hearing was considered and dealt with in the PIH Decision and Order of the Tribunal where it found that the applicant's conduct did not attract an award for costs. I must therefore consider the applicant's conduct following the PIH Decision and Order.

[57] I concede that the respondent was successful in raising its preliminary issue and that the Tribunal decided that it was premature for the applicant to file an application for benefits before the expiry of the two-year CAT timeframe. The Tribunal dismissed all of the substantive issues, however, the Tribunal concluded that it was appropriate to continue the application with the sole issue in dispute being a claim for an award. In this sense, proceeding with this hearing was appropriate and reasonable.

[58] The respondent's submissions on the issue of an award included allegations of the applicant being disingenuous and misleading in her facts. As I referenced above, it was only after reviewing the evidence of both parties that I was able to have a clear picture of the totality of the facts and events that transpired. This is the foundation of our adversarial system: the applicant provided her evidence, the respondent had the opportunity to respond with its evidence, and I considered the totality of the evidence to come to a decision.

[59] The Tribunal ordered that the applicant could proceed with her application for an award and the applicant did so. Both parties submitted their evidence and a decision was rendered. Although the applicant was unsuccessful in her claim for an award, I do not find this result an appropriate reason to grant costs.

[60] The respondent's request for costs is denied.

ORDER

[61] For the above reasons, I find:

i. The respondent is not liable to pay an award;

ii. The respondent is not entitled to costs; and

iii. The application is dismissed.

Released: September 18, 2025

Trina Morissette
Vice-Chair