Citation: Akhuanzada v. Aviva Insurance Company of Canada, 2025 ONLAT 24-002749/AABS

Licence Appeal Tribunal File Number: 24-002749/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:

Qandeel Akhuanzada

Applicant

and

Aviva Insurance Company of Canada

Respondent

DECISION

ADJUDICATOR: **Amar Mohammed**

APPEARANCES:

For the Applicant: Anh Vo, Paralegal

For the Respondent: Rachel Jadd, Counsel

HEARD: **By Way of Written Submissions**

OVERVIEW

[1] Qandeel Akhuanzada, the applicant, was involved in an automobile accident on October 8, 2021, 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 - Automobile Accident Benefits Service (the "Tribunal") for resolution of the dispute.

ISSUES

[2] The issues in dispute are:

i. Is the applicant entitled to an income replacement benefit ("IRB") in the amount of $40.38 per week from December 27, 2022 to October 5, 2023 and $185.00 per week from October 6, 2023 to date and ongoing?

ii. Is the respondent entitled to a repayment of $14,381.91 relating to its payment of an income replacement benefit ("IRB") for the period of October 15, 2021 to October 5, 2023?

iii. Is the applicant entitled to $2,296.50 for physiotherapy and massage services, proposed by Focus Physiotherapy in a treatment plan/OCF-18 ("plan") submitted September 15, 2022?

iv. Is the applicant entitled to the plans proposed by Pain Rehabilitation Clinic, as follows:

a. $2,000.48 for physiotherapy and massage services, submitted December 21, 2022;

b. $200.00 for an examination (OCF-3 Disability Certificate), dated December 27, 2022;

c. $2,600.64 for multidisciplinary treatment, submitted March 20, 2023;

d. $2,200.00 for a chronic pain assessment, dated July 12, 2023;

e. $3,200.80 for multidisciplinary treatment, dated September 20, 2023; and

f. $200.00 for examinations (OCF-3 Disability Certificate), dated September 27, 2023?

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

[3] The applicant's entitlement to the following plans proposed by Pain Rehabilitation Clinic were withdrawn as issues at the hearing:

a. $1,230.00 ($3,030.00 less $1,800.00 approved) for social work counselling, submitted July 26, 2023; and

b. $1,230.00 ($3,030.00 less $1,800.00 approved) for social work counselling, submitted May 16, 2024.

RESULT

[4] The applicant is not entitled to a post-104-week IRB or to interest. The respondent is not entitled to repayment of the IRB in the amount of $14,381.91 and it is therefore unnecessary to assess whether the applicant is entitled to a lower pre-104-week IRB than has already been paid. The applicant is entitled to the chronic pain assessment, plus interest. The rest of the application is dismissed.

PROCEDURAL ISSUES

Submissions that do not comply with the filing requirements

[5] The respondent alleges that the applicant's written submissions do not comply with the 12-page limit set for the applicant's submissions at this hearing. This Tribunal issued a Motion Order released November 29, 2024, granting conversion of a video hearing to a written hearing, on consent. The Motion Order includes the following orders:

i. All submissions, evidence and authority briefs filed with the Tribunal must be double-spaced, 12-point, Arial or Times New Roman font with 1.5-inch margins and be indexed, bookmarked/tabbed and consecutively paragraph and page numbered. Submissions must make specific reference to the evidence and authorities by tab and page number.

ii. The page limits are exclusive of evidence and authorities. The hearing adjudicator has the discretion to determine whether to consider submissions that do not comply with the filing requirements.

[6] The applicant argues an oversight led to the non-compliance. The applicant thought she had a 15-page limit, but the applicant noticed the 12-page limit on

the day submissions were due. The applicant states that the following steps were taken in order to comply with the Order after realizing the oversight:

i. Reference to evidence was excluded from submissions,

ii. Two issues were withdrawn,

iii. The respondent was notified of the oversight.

[7] Still, I find that the applicant's submissions, as filed, do not comply with the Tribunal's Motion Order. Although the filed submissions are 12 pages, the margins and font size are non-compliant. The use of narrow margins and in part, the use of a tiny font size, seem to be an effort to create a 12-page document for filing at the Tribunal to give the appearance of compliance. The applicant did not address this until the respondent raised it in its responding submissions. The respondent has requested I consider up to paragraph 27 and nothing beyond that point. In coming to my decision, I considered:

i. the nature of the disputes that come before this Tribunal and this applicant's vulnerability,

ii. the consumer protection nature of the governing legislation,

iii. that the respondent requested that I not consider the applicant's submissions beyond page 10 of the submissions as they were filed. Page 10 of the applicant's filed submissions end at paragraph 27, addressing the issue of post-104-week IRB,

iv. the applicant's arguments about prejudice if I did not consider any of her submissions on the remaining issues in dispute,

v. that the respondent has not established any prejudice from the applicant's non-compliance and was able to reasonably respond to the submissions on all issues.

[8] Although, in my view, it is open to me to refuse to consider the applicant's submissions which exceed the prescribed limits, I have decided to consider the entirety of the applicant's submissions to determine the issues in dispute on their merits. The portions of the applicant's submissions which exceed the prescribed page limit concern the various treatment plans in dispute. I find that the applicant would be significantly prejudiced if I refused to consider her submissions which exceed the prescribed page limit under these circumstances.

[9] For the reasons above, I am considering the applicant's complete submissions.

ANALYSIS

The applicant is not entitled to a post-104- week IRB in the amount of $185.00 per week from October 6, 2023 to date and ongoing.

[10] The applicant is not entitled to a post-104-week IRB.

[11] To receive payment for a post-104-week IRB under s. 6 of the *Schedule*, the applicant must demonstrate on a balance of probabilities that they suffer from a complete inability to engage in any employment or self-employment for which they are reasonably suited by education, training or experience. It is well established that the test for post-104-week IRB is a more stringent test than the pre-104-week IRB test and applies in the context of ongoing entitlement to IRB: *Paesano v. Coseco Insurance Co.*, 2025 ONSC 3245, at para. 41.

[12] The applicant refers me to a Disability Certificate completed by Dr. Bui dated December 21, 2022, which states the applicant was substantially unable to perform the essential tasks of her employment. However, the essential tasks are not identified for her position as a salesperson and manager at her husband's shoe store. The applicant argues she meets the more stringent post-104-week test including on the basis of her limited education, training and experience combined with her physical and psychological conditions. The applicant argues that due to the time elapsed since the accident, it is increasingly tough to find and sustain competitive employment, even with accommodations. I was not referred to evidence that may establish this. As the respondent argues, I find that the applicant's arguments relating to the post-104-week test are unsupported by medical opinion.

[13] The applicant also argues she is deteriorating. As an example, Dr. Ilk notes the applicant's complaint of her English getting worse in August 2024. The applicant also refers me to the psychological insurer's examination report dated September 1, 2022, in which Dr. Kelly McCutcheon, Psychologist, noted the applicant's disproportionate occupation with her pain and suffering. Even if I accept the applicant's English is getting worse to some degree over time and that she is disproportionately occupied with her pain, this does not establish that the applicant suffers a complete inability to engage in any employment.

[14] The respondent's position is that the applicant has not presented any medical opinion that states she suffers from a complete inability to engage in any employment as required by the test. The respondent refers me to Dr.

McCutcheon's opinion that from a psychological perspective, the applicant is capable of performing her pre-accident employment tasks. This opinion is similarly shared from a physical perspective by the insurer examiner, Dr. Irina Safir, a General Practitioner, in a report dated September 1, 2022. I do not need to give the opinions of the insurer's assessors any weight for two main reasons, the onus is on the applicant to establish entitlement to a post-104-week IRB and reports address the pre-104-week test, not the post-104-week test.

[15] I am sympathetic to the applicant's complaints of deterioration and occupation with pain. However, I am not persuaded that the applicant suffers from a complete inability to engage in any employment or self-employment for which she is reasonably suited by education, training or experience.

[16] For the reasons above, the applicant is not entitled to a post-104-week IRB.

Is the respondent entitled to a repayment of $14,381.91 relating to its payment of an income replacement benefit for the period October 15, 2021 to October 5, 2023? If so, is the applicant entitled to pre-104-week IRB of $40.38 per week from December 27, 2022 to October 5, 2023?

[17] I find that the respondent is not entitled to a repayment of the IRB paid to the applicant and it is therefore unnecessary to assess whether the applicant is entitled to the lower amount of pre-104-week IRB.

[18] Under s. 52(1)(a) of the *Schedule*, a person is liable to repay to the insurer any benefit that is paid as a result of an error on the part of the insurer, the insured person or any other person, or as a result of wilful misrepresentation or fraud. Section 52(2) specifies that the insurer shall give the person notice of the amount that is required to be repaid, and s. 52(3) provides timelines for repayment requests. If the notice required is not given within 12 months after the payment of the amount that is to be repaid, the person to whom the notice would have been given ceases to be liable to repay the amount unless it was originally paid to the person as a result of wilful misrepresentation or fraud.

[19] The respondent argues and bears the onus to establish that there was misrepresentation, and that the misrepresentation was wilful. The applicant argues that the respondent's payment request notice was not proper as it did not identify the period for which repayment is sought.

[20] The applicant points me to the decision in *Intact Insurance Company v Marianayagam*, 2016 ONSC 1479 ("*Intact*"). At paragraph 45, the court states that:

> A payment request notice pursuant to s. 47 should contain: (a) identification of the type of benefit that was overpaid; (b) the payment period for which repayment is sought; and (c) the amount of repayment sought. See *Knechtel and Royal & SunAlliance Company of Canada*, (FSCO, Arbitrator Sampliner, June 15, 2009); *Cromwell v. Liberty Mutual Insurance Co.*, supra at para. 46. Given that the proper amount of the deduction is sometimes debatable, in my opinion, the amount claimed need not be perfectly correct, but it should be substantially correct.

[21] It is apparent from the court's review earlier in the decision, at paragraph 42 of *Intact*, that the court was dealing with a dispute involving an old version of the *Schedule* that does not apply to this dispute. However, s. 47(2)(a) as quoted and referred to by the court is largely identical to s. 52(2)(a) that applies in this case. Where the old version refers to individuals that are *required* to repay an amount, the current version refers to individuals that are *liable* to repay an amount. For purposes of the dispute before me this difference is inconsequential, and the case is binding on me.

[22] The court referred to three separate pieces of information that should be included in a proper notice requesting payment from an insured. The three elements that make up a proper notice are, the type of benefit, the repayment period, and the repayment amount sought. I must assess all three within the respondent's notice. While the court was dealing with the repayment amount I am dealing with the applicant's argument that the period for which repayment is sought is missing from the notice. On this point, I note that the court's approach was not simply whether the notice contained the required information but also if it was substantially correct, rather than perfectly correct. In the court's opinion, the notice was not a proper notice because while it contained an amount sought for repayment, the amount was grossly incorrect. In my opinion, I should take the same approach. This means, for the repayment notice to be proper, the period for which repayment is sought should be in the notice and should be substantially correct.

[23] The respondent sent a notice by letter dated October 1, 2024 in which it relies on s. 52(2)(a) of the *Schedule*. The key portions of the letter state as follows:

> Our determination is based on you wilfully misrepresenting your pre-accident earnings, by providing documentation indicating that you worked consistently and earned $36,000 in the year prior to the above accident, as well as paystubs (with deductions for CPP),

> despite your payment of cash during that timeframe, and possibility that you were not actively engaged in employment as reported.
>
> In addition, our records indicate that a total payment of Income Replacement Benefits in the amount of $14,381.91 was paid to you based on the information you had provided. As we have determined that you have willfully misrepresented this information, in accordance with Section 52 of the Statutory Accident Benefits Schedule, we are requesting full repayment in the amount of $14,381.91.

[24] I find in favour of the applicant that the payment period for which repayment is sought is missing from the respondent's notice. I find that the respondent's notice does not identify when the period begins or ends. The respondent's position that the notice confirms the total amount of IRB paid to the applicant and since this is the same as the total amount of IRB sought for repayment, the period is implied as "the entire time" during which the applicant received IRB. I am not persuaded by this argument because the amount and the period are separate elements of a proper notice and in my opinion should not be conflated.

[25] I find that the references in the notice to amounts do not include a reference to either the period in which the payments were made, or the period for which the repayment is sought. The notice referring to the amount sought is not sufficient as this is a separate element of a proper payment request.

[26] Ultimately, in my view, without the notice indicating the period for which repayment is sought the notice is not proper as set out in *Intact*. Further, I cannot scrutinize whether the period in the notice is correct and to what degree, which is an important aspect of my function in this case based on the approach taken by the court in *Intact*. Although the period was clarified for the purposes of this hearing, it is my opinion that that the respondent cannot cure a defective notice during or following a hearing just as a respondent cannot cure a defective denial in this way, which is well established.

Applicant's non-compliance with orders and undertakings

[27] The respondent requests that I draw an adverse inference against the applicant for non-production of the following documents and things required by the Case Conference Report and Order:

i. Bank records from January 1, 2020 to February 25, 2021 and September 1, 2021 to September 28, 2021 (i.e. the month prior to the accident);

ii. Copy of her employment file from January 1, 2020 to the date of the Case Conference (including specific requests for all paystubs, attendance records, and her ROE);

iii. Copy of her EI, CPP-D, OW and ODSP files; and

iv. Copy of draft reports from all assessments attended by the applicant.

[28] The respondent also asks that I draw an adverse inference against the applicant for non-production of metadata associated with the paystubs she provided for 2021, which she undertook to provide at her Examination Under Oath ("EUO") held on August 23, 2024 in relation to her entitlement to IRBs and the Respondent's claim for repayment.

[29] The applicant argued against this position citing best efforts were made. Ultimately, it is moot whether I draw a negative inference or not because this information is predominantly relevant to the respondent's argument on wilful misrepresentation. However, the issue of repayment is being decided on the basis of an improper repayment notice, rather than the substance of the respondent's arguments on wilful misrepresentation where a negative inference may be a factor.

[30] For the reasons above, the respondent's notice seeking repayment was improper and therefore the respondent is not entitled to a repayment of $14,381.91 in IRB paid to the applicant. Given this finding, it is not necessary to engage in an analysis of the parties' other arguments relating to repayment. It is also unnecessary to assess if the applicant is entitled to a lower amount of pre-104-week IRB when she has already received a higher amount per week during that period and is not required to repay it.

Is the applicant entitled to the plans proposing: $2,296.50 for physiotherapy and massage services, $2,000.48 for physiotherapy and massage services, $2,600.64 for multidisciplinary treatment, and $3,200.80 for multidisciplinary treatment?

[31] I find that the applicant is not entitled to these plans proposing treatment.

[32] 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.

[33] The applicant argues she is entitled to the plans due to ongoing pain resulting from exacerbation of her pre-existing conditions and these treatment plans would effectively reduce her pain. The applicant supports her position by referring to evidence of “Dr. Ilk’s diagnosis of fibromyalgia on October 13, 2022; February 14, 2023 MRI of the back; [Dr. Larissa Lisnevskaia’s] diagnosis of Rheumatoid Arthritis on July 27, 2023; and February 15, 2024 MRI of the back.” The applicant argues that Dr. Ilk advised the applicant to take her MRI results of February 2023 to her rehabilitation provider so they could help her and if it was not helpful, Dr. Ilk would refer her to a pain clinic for injections or to a neurosurgeon. The applicant argues that since Dr. Ilk did not make a referral until a year later, I should accept this as evidence that the treatment was effective. I agree with the respondent that this lack of referral being evidence of her treatment being effective is speculative.

[34] The respondent refers me to Dr. Safir’s report dated July 28, 2023 that the applicant reported “0 improvement” in her pain complaints as a result of treatment. I find that the applicant’s reporting to her treatment provider, Pain Rehabilitation Clinic, and to Dr. Safir confirming no improvement in her pain are consistent. I sympathize with the applicant feeling that treatment was helping achieve pain reduction, but her submissions do not align with evidence of her own reporting which seems to be clear that there was no improvement. If treatment was helping her in some way it was not for pain reduction as argued by the applicant.

[35] The applicant referred me to Pain Diagrams the applicant completed at the Pain Rehabilitation Clinic, between March and September 2023 which seem to confirm there was no improvement. The applicant indicated, in chronological order:

i. On March 17, 2023 she felt treatment was helping and rated her pain 8-9 on a scale of 10.

ii. On May 24, 2023 she felt treatment was good and rated her pain 9-10, where 10 means the worst possible pain.

iii. On July 26, 2023 she felt because of treatment she was getting better and rated her pain 8-9.

iv. On September 20, 2023 she felt treatment was helping her pain and rated her pain a 10, meaning the worst possible.

[36] The applicant also argues that her physical and psychological symptoms are intertwined and that improving her pain also alleviates her psychological condition. The respondent argues that this is not supported by evidence, however, I comment on evidence of this in considering entitlement to the chronic pain assessment. In any case, the evidence shows treatment did not improve her pain between March and September of 2023. Since treatment has not provided any improvement in pain and that is the main goal as argued by the applicant, the plans are not necessary.

[37] The respondent also argued that plans for $2,000.48, $2,600.64 and $3,200.80 were not compliant with the Professional Service Guidelines because they proposed bulk billing for interdisciplinary services. The respondent refers me to *Luong v Aviva General Insurance Company*, 2023 CanLII 4456, paras 28,31, 41-42. I am persuaded by the Tribunal's previous decision that where a plan proposes bulk or block billing for interdisciplinary services, I cannot determine the reasonableness of the proposed rates. For example, the plan proposing $2,000.48 of services estimated 12 sessions of physical rehabilitation by Dr. San Bui, Chiropractor, at a quantity of 1.33, measured per hour, at a cost of 150.04 per session. However, the additional comments section states that they are forced to measure the service on an hourly basis, but they actually treat the patient on a per session basis combining the services of "a. Massage and/or b. Chiropractic and/or c. Acupuncture and/or d. Physical therapy/modality such as laser, ultrasound and various forms of electrotherapy and/or e. Active rehabilitation session." As a result, I have a lack of information to assess the reasonableness of the plans.

[38] I find, on a balance of probabilities, that the applicant is not entitled to these plans because they are not reasonable and necessary.

Is the applicant entitled to the plan proposing $2,200.00 for a chronic pain assessment?

[39] I find that the applicant is entitled to this plan proposing a chronic pain assessment.

[40] For an applicant to prove that an assessment is reasonable and necessary, it is not crucial for the applicant to prove the actual existence of a condition; rather, the applicant must prove that there is some objective evidence to suggest that some condition exists and warrants investigation via an assessment.

[41] The applicant refers me to ongoing pain complaints as well as deterioration as evidence suggesting that a chronic pain assessment is warranted. The

respondent argues, based on Dr. Safir's opinion, that the chronic pain assessment would not be expected to benefit the applicant beyond the ongoing management available through the family doctor. The respondent argues that if the applicant's family doctor thought it was reasonable and necessary she would have made a chronic pain assessment referral, but she did not. I find this argument speculative. The respondent further argues this assessment is available to the applicant through OHIP and she bears the onus of establishing that it was not available through OHIP. The respondent refers me to s. 47(2) of the *Schedule*:

> Payment of a medical, rehabilitation or attendant care benefit or a benefit under Part IV is not required for that portion of an expense for which payment is reasonably available to the insured person under any insurance plan or law or under any other plan or law.

[42] The respondent refers me to *Patel v. Allstate Insurance Company*, 2021 CanLII 124053 paras 16-17 confirming the applicant has the burden of proving that the service is not reasonably available elsewhere. In that case, the applicant had not disputed with evidence that the assessment was not available under OHIP whereas the applicant was required to use reasonable efforts and accept reasonable delays. The Tribunal was not persuaded in that case that an assessor's comment on wait times addressed actual availability. However, I have evidence before me that referrals for chronic pain were being denied by a clinic that the applicant was referred to by her family doctor. For this reason, I am persuaded that the service was not reasonably available to the applicant and this is beyond an issue of delay.

[43] In this case, on February 10, 2023 the applicant's family doctor, Dr. Ilk, noted a diagnosis of chronic pain, likely fibromyalgia, worse since the accident, and depression, awaiting psychiatrist. The applicant was referred to Dr. Rusty Goodman, MDCM, FRCP(C) for rheumatology. On March 7, 2023, Dr. Goodman declined the referral citing high patient clinical volumes and long waiting lists. The letter is clear that they were not accepting any referrals for the following, which clearly includes chronic pain:

i. Chronic pain or fatigue,

ii. Mechanical neck and back pain,

iii. Fibromyalgia.

[44] On May 24, 2023, Dr. Laura Gage noted in a psychiatry visit that the applicant had previously visited in 2015 and was diagnosed with major depressive disorder, recurrent with full inter-episode recovery, noting two previous episodes. Further, it is noted that the applicant is suffering from a Major Depressive Disorder for one year which is complicated by chronic pain. Also noted is chronic arthralgia pain for 8 years worsened after the accident. Chronic foot and back pain making walking and standing difficult. It is also noted that the applicant's family doctor is considering fibromyalgia and ruling out inflammatory arthritis with rheumatology. The applicant's main stressors by her family doctor are noted to be chronic pain and her mental health symptoms. On the basis of the above, in my view, the applicant's evidence suggests there is some condition that warrants a chronic pain assessment.

[45] I find, on a balance of probabilities, that the applicant is entitled to this plan because it is reasonable and necessary.

Is the applicant entitled to $200.00 for OCF-3 Disability Certificate, dated December 27, 2022 and $200.00 for OCF-3 Disability Certificate, dated September 27, 2023?

[46] The respondent concedes the applicant's entitlement to the charges for preparing the December 27, 2022 Disability Certificate and that the payment was made on February 12, 2025. This was not disputed by the applicant in her reply submissions. I find that the applicant is not entitled to $200.00 for the OCF-3 Disability Certificate, dated September 27, 2023.

[47] The applicant argues she is entitled to the charges for the second Disability Certificate because it was submitted along with triage records and x-ray report of the right knee. The applicant's position is that it was reasonable to submit this Disability Certificate because it allows the respondent to identify the applicant's injuries and decide whether to schedule an insurer examination.

[48] The respondent relies on, and I am persuaded by the Tribunal's decision, *Yadroozeh v Aviva Insurance Company*, 2021 CanLII 111171, paras 43-45. At paragraph 44 the Tribunal found that the *Schedule* is clear when an insurer is obligated to pay for completion of a Disability Certificate and that an insured choosing to update the respondent does not make the insurer liable. Similar to that case, in the case before me, the applicant did not advance evidence that the second Disability Certificate was required under s. 21, s. 36 or s. 37 of the *Schedule* as part of the applicant's application for a specified benefit. I also did not find evidence that the respondent had requested the second Disability Certificate.

[49] I find, on a balance of probabilities, that the applicant is not entitled to $200.00 for the OCF-3 Disability Certificate, dated September 27, 2023.

Interest

[50] The applicant is entitled to interest on overdue benefits pursuant to s. 51 of the *Schedule.*

ORDER

[51] For the reasons above, I make the following orders:

i. The respondent is not entitled to repayment of the pre-104-week IRB in the amount of $14,381.91. It is not necessary to assess a lower pre-104-week IRB in this context.

ii. The applicant is not entitled to a post-104-week IRB.

iii. The applicant is entitled to the chronic pain assessment, plus interest.

iv. The rest of the application is dismissed.

Released: October 28, 2025

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Amar Mohammed
Adjudicator