Citation: Lingeswaran v. Aviva General Insurance Company, 2026 ONLAT 24-000549/AABS - R

RECONSIDERATION DECISION

Before:	**Tyler Moore, Vice-Chair**
Licence Appeal Tribunal File Number:	**24-000549/AABS**
Case Name:	**Niruja Lingeswaran v. Aviva General Insurance Company**

Written Submissions by:

For the Applicant:	Aparajita Singh, Counsel
For the Respondent:	Jonathan Charland, Counsel

OVERVIEW

[1] On December 30, 2025, the applicant requested reconsideration of the Tribunal's decision dated December 2, 2025 ("decision").

[2] The Tribunal found that the applicant was not entitled to the treatment plans for chiropractic and psychological services, attendant care benefits ("ACBs"), interest, and award in dispute.

[3] The grounds for a request for reconsideration are found in Rule 18.2 of the *Licence Appeal Tribunal Rules, 2023* ("Rules"). To grant a request for reconsideration, the Tribunal must be satisfied that one or more of the following criteria are met:

a) The Tribunal acted outside its jurisdiction or committed a material breach of procedural fairness;

b) The Tribunal made an error of law or fact such that the Tribunal would likely have reached a different result had the error not been made; or

c) There is evidence that was not before the Tribunal when rendering its decision, could not have been obtained previously by the party now seeking to introduce it, and would likely have affected the result.

[4] The applicant seeks reconsideration pursuant to Rule 18.2(b). The applicant seeks an order approving the disputed treatment plans and ACBs, awarding interest, and granting an award.

[5] The respondent submits that the request for reconsideration should be dismissed.

RESULT

[6] The applicant's request for reconsideration is dismissed.

ANALYSIS

[7] The test for reconsideration under Rule 18.2 involves a high threshold. The reconsideration process is not an opportunity for a party to re-litigate its position where it disagrees with the Tribunal's decision, or with the weight assigned to the evidence. The requestor must show how or why the decision falls into one of the categories in Rule 18.2.

Did the Tribunal make an error of law or fact such that the Tribunal would likely have reached a different result had the error not been made?

[8] I find that the applicant has not established grounds for reconsideration that would meet the threshold needed to grant reconsideration under Rule 18.2(b).

Treatment plan in the amount of $4,040.00 for chiropractic services

[9] The applicant submits that the Tribunal erred by barring review of the treatment plan under s. 38(5) and s. 38(6) of the *Schedule* based on the applicant's initial classification under the MIG and the respondent's payment of an OCF-23 form. According to the applicant, the Tribunal improperly substituted the claim's administrative history for a substantive analysis as to whether the applicant's impairments remained "minor" at the relevant time.

[10] The applicant also submits that the MIG applicability is not static, and that it demands an ongoing assessment of the evidence to determine if one's injuries evolve beyond "predominantly minor injuries" as defined in s. 3(1) of the *Schedule*. The applicant argues that the Tribunal did not weigh the substantial medical evidence of her persistent symptoms, and she relies on *18-007308 v. Aviva Insurance Canada*, 2019 CanLII 72229 (ONLAT) ("*18-007308*") to support her position.

[11] The respondent submits that the applicant did not address its position with respect to s. 38(5) and s. 38(6) of the *Schedule* at first instance. As a result, her reconsideration submissions are an attempt to raise a new argument and re-argue her case.

[12] Section 38(5) of the *Schedule* sets out that an insurer may refuse to accept a treatment plan if the plan describes goods and services to be received in respect of any period during which the insured person is entitled to receive goods or services under the MIG in respect of the impairment.

[13] Section 38(6) sets out that an insurer's refusal to accept a treatment and assessment plan under subsection (5) is final and is not subject to review.

[14] I find no error in the way the Tribunal addressed and accepted the respondent's position with regards to s. 38(5) and s. 38(6) of the *Schedule* at paragraphs 9 and 12 of the decision. In addition to the fact that I am not bound by *18-007308*, I find that it is distinguishable on the facts. In that decision, the treatment plans in dispute were proposed two years after the subject accident. In this case, the treatment plan was proposed just 11 days after the subject accident.

[15] At paragraph 9 of the decision, the Tribunal noted that:

> "on October 26, 2022 the treatment provider submitted an OCF-23 as requested, and the respondent paid for treatment under that plan up to the MIG limit. There is no evidence that any treatment under the denied OCF-18 was incurred or remains outstanding. Accordingly, the dispute concerns a plan that was never implemented, as the provider chose to proceed under the approved MIG plan."

[16] I also note that the completed OCF-23, acknowledging MIG related injuries, was submitted months after the disputed treatment plan was first proposed.

[17] At paragraph 12 of the decision, the Tribunal concluded that:

> > "the applicant was appropriately classified under the MIG based on the initial diagnosis of soft-tissue injuries. The clinic submitted an OCF-23 and received payment for treatment under the MIG. There is no evidence that any treatment under the denied OCF-18 was incurred or remains outstanding, nor that it is reasonable and necessary."

[18] At paragraph 11 of the decision, the Tribunal noted that the applicant did not address the respondent's reliance on s. 38(5) and s. 38(6) at first instance, and that neither party provided the date on which the applicant was determined to be outside of the MIG. For these reasons, I find that this part of the applicant's reconsideration request constitutes an attempt to introduce a new argument that was not addressed at first instance.

[19] I find that the applicant has not demonstrated that the Tribunal made an error of fact or law such that it would likely have reached a different result had the error not been made.

Treatment plan in the amount of $2,910.00 for chiropractic services

[20] The applicant submits that the Tribunal denied entitlement on the ground that the treatment plan was not entered into evidence, without regard for the medical evidence describing her injuries and ongoing symptoms. According to the applicant, this elevates procedural formality over substantive justice.

[21] The applicant also submits that the Tribunal erred by treating s. 33 non-compliance as determinative of entitlement. The applicant argues that s. 33 of the *Schedule* is a procedural mechanism intended to assist insurers in adjusting claims, but non-compliance results only in a temporary suspension of benefits during the period of non-compliance and not a permanent bar from entitlement.

According to the applicant, a balanced review of the evidence would likely support the reasonableness of the treatment plan.

[22] Though the applicant included the treatment plan with her reconsideration submissions, I find that she has not shown that the document was unavailable when she filed her initial submissions, thereby not meeting the test under Rule 18.2(c).

[23] I find that the Tribunal did not deny entitlement solely because it was not entered into evidence. I also find that, in discharging her onus at first instance, the applicant did not identify the treatment goals, how those goals would be met to a reasonable degree, and that the overall costs were reasonable. These are essential aspects of the analysis for entitlement.

[24] At paragraphs 19 and 20 of the decision, the Tribunal considered the medical evidence, including the assessment reports of physician, Dr. Alan Kruger, and orthopaedic surgeon, Dr. Osama Benmoftah. Based on its analysis of the medical evidence, the Tribunal found that the applicant had not met her onus of establishing that the proposed treatment for chiropractic services was reasonable and necessary.

[25] At paragraphs 16-18 and 21 of the decision, the Tribunal outlined s. 33(1) and s. 33(6) of the *Schedule,* and it found the respondent correctly suspended medical benefits, effective January 23, 2024, after a request for updated medical records was made when the treatment plan was denied on January 2, 2024.

[26] The applicant did not submit that she ever complied with the respondent's s. 33 request for updated medical records. As a result, the Tribunal found that the plan was not payable due to non-compliance with s. 33 at paragraph 21 of the decision. I find that s. 33(6) clearly sets out that an insurer is not liable to pay benefits during any period of non-compliance.

[27] I find that the applicant has not demonstrated that the Tribunal made an error of law or fact such that it would likely have reached a different decision had the error not been made.

Partially approved treatment plans for psychological services with disputed amounts of $1,690.35 and $1,859.38

[28] The applicant submits that the Tribunal erred in approving only the respondent's proposed provider hourly rate of $99.75 without an analysis of reasonableness based on the provider's qualifications, the nature of the services, and the

applicant's specific needs. According to the applicant, the Tribunal did not justify why a lower or higher rate was reasonable, dismissing the claimed rate without evidence.

[29] The applicant also submits that progress reports were rejected as unnecessary despite her submissions that they were integral to monitoring and adjusting treatment for the applicant's conditions and impairments.

[30] The respondent submits that the applicant did not put forward any evidence of the provider's qualifications or make submissions with respect to the appropriateness of the approved hourly rate at first instance.

[31] The respondent also submits that it is well settled that submissions are not evidence, and the applicant's lack of evidence led the Tribunal to make a factual finding that the progress reports were not reasonable and necessary.

[32] At paragraph 29 of the decision, the Tribunal set out that "the applicant did not make submissions regarding the appropriateness of the $99.75 hourly rate, nor did she provide evidence that the psychotherapist possessed qualifications warranting the high psychologist rate of $149.61." As a result, I find that the applicant's reconsideration submissions related to the partially approved treatment plans for psychological services constitute an attempt to re-argue her case, which is not grounds for reconsideration under Rule 18.2.

[33] I also find that the applicant has not demonstrated that the Tribunal made an error of law or fact in denying the disputed progress reports. The applicant's disagreement with the Tribunal's decision regarding the progress reports does not warrant reconsideration under Rule 18.2.

Attendant Care Benefits

[34] The applicant submits that the Tribunal erred in applying s.19 of the *Schedule*.

[35] According to the applicant, s. 19 entitles an insured to reasonable and necessary attendant care services, regardless of whether they are incurred in a commercial sense. Attendant care provided by family members qualifies as incurred if evidence shows that the services were provided, the need existed, and economic loss or value can be inferred. The applicant submits that the Tribunal dismissed evidence of family assistance for partial abilities and equated that partial independence with no need. The applicant relies on *J.W. v Security National Insurance Company*, 2020 CanLII 30385 (ONLAT) ("*J.W.*") to support her position.

[36] The applicant also argues that the Tribunal overlooked key evidence, including the May 2023 occupational therapy in-home assessment report of Varun Madan and the June 2024 orthopaedic assessment report of Dr. Benmoftah confirming functional limitations.

[37] I find that the applicant has not shown that the Tribunal improperly applied the *Schedule.* The applicant has not provided evidence of incurred expenses that have been submitted for reimbursement or evidence of economic loss of her family members that would support the amount claimed for ACBs. This is required under s. 3(7) and s. 19 of the *Schedule*. I also find that it considered the May 2023 occupational therapy assessment report and June 2024 orthopaedic assessment report, in addition to other medical evidence, at paragraphs 33-43 of the decision.

[38] At paragraph 37 of the decision, the Tribunal noted that the applicant did not submit a Form-1 into evidence. Though the applicant introduced the Form-1 with her reconsideration submissions, it was not introduced at first instance, and she has not shown that it would not have been available at that time. She has again not met the test under Rule 18.2(c).

[39] At paragraph 38 of the decision, the Tribunal acknowledged the findings of Ms. Madan but relied on the fact that the applicant did not provide "corroborating clinical documentation" or evidence of incurred attendant care expenses or evidence of economic loss of the family members who reportedly provided the assistance to the applicant, as required by s. 3(7)(e) and s. 19(1) of the *Schedule*.

[40] At paragraph 41 of the decision, the Tribunal found that "the applicant's own reports indicate a level of independence inconsistent with the claimed need for assistance." I find that the applicant's disagreement with the Tribunal's weighing of the medical evidence is not grounds for reconsideration.

[41] I also find that *J.W* can be distinguished from this case on the facts. In *J.W,* the applicant sustained catastrophic injuries and although they were found to be entitled to ACB, none were payable to date because the amounts did not meet the definition of "incurred" and they could not be deemed incurred. In this case, however, the Tribunal also found that the applicant did not provide evidence of incurred expenses.

[42] For these reasons, I find that the applicant has not demonstrated that the Tribunal made an error of law or fact such that it would likely have reached a different decision with respect to ACB entitlement had the error not been made.

Interest and Award

[43] I am not satisfied that the Tribunal made an error of law or fact in dismissing the applicant's claim for interest and an award.

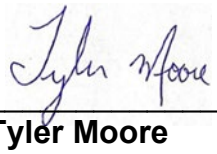
[44] The applicant submits that interest is payable on all overdue benefits and that she is entitled to an award pursuant to s. 10 of the *Schedule* because the respondent improperly restricted her from the treatment plans in dispute and withheld ACBs.

[45] At paragraph 48 of the decision, the Tribunal made a factual finding that there was no basis to conclude that any payment was unreasonably withheld or delayed, as no benefits were payable.

[46] As no benefits are payable, the Tribunal correctly found that the applicant is not entitled to interest or an award.

CONCLUSION & ORDER

[47] The applicant's request for reconsideration is denied.



Tyler Moore
Vice-Chair

Released: April 17, 2026