



Citation: Yiu v. TD General Insurance Company, 2026 ONLAT 25-000903/AABS

Licence Appeal Tribunal File Number: 25-000903/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:

Che Tung Yiu

Applicant

and

TD General Insurance Company

Respondent

DECISION

ADJUDICATOR: Aric Bhargava

APPEARANCES:

For the Applicant: Rakesh Sharma, Counsel

For the Respondent: Selina Ferenac, Counsel

HEARD: By way of written submissions

OVERVIEW

- [1] Che Tung Yiu, the applicant, was involved in an automobile accident on February 15, 2024, 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, TD General 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 \$3,749.56 for physiotherapy services, proposed by Total Recovery Rehab Centre in a treatment plan/OCF-18 dated January 16, 2025?
 - ii. Is the applicant entitled to interest on any overdue payment of benefits?
 - iii. Is the respondent liable to pay an award under section 10 of Regulation 664 because it unreasonably withheld or delayed payments to the applicant?
- [3] The Case Conference Report and Order (“CCRO”) dated May 27, 2025 lists a preliminary issue in which the respondent seeks to bar the applicant from proceeding with their claim for physiotherapy services on the basis of non-attendance for an insurer’s examination. The respondent’s hearing submissions state that it has withdrawn the preliminary issue because the applicant subsequently attended a section 44 insurer’s examination on June 23, 2025.

RESULT

- [4] For the reasons below, I find that:
- i. The applicant is not entitled to the treatment plan for physiotherapy services in a plan dated January 16, 2025.
 - ii. The applicant is not entitled to interest.
 - iii. The respondent is not liable to pay an award.

ANALYSIS

The OCF-18 for physiotherapy treatment, dated January 16, 2025, is not reasonable and necessary

- [5] I find the applicant is not entitled to the treatment plan for physiotherapy services dated January 16, 2025.
- [6] To receive payment for a treatment and assessment plan under section 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, identify how the goals would be met to a reasonable degree, and establish that the overall costs of achieving them are reasonable.
- [7] The treatment plan dated January 16, 2025, prepared by Mr. Ahmed Afifi, physiotherapist, for \$3,749.56 for physiotherapy services proposed by Total Recovery Rehab Centre, outlines sixteen sessions of one-hour physiotherapy, sixteen sessions of half-hour active therapy, sixteen sessions of one-hour massage therapy, reassessment, and a progress report, over a period of eight weeks. The goals of the plan include pain reduction, increase in strength, increased range of motion, return to activities of normal living, and return to pre-accident work activities; progress will be evaluated through subjective/objective assessment, pain scale and other measures.
- [8] The applicant submits that the physiotherapy treatment plan is reasonable and necessary and relies on the treatment and assessment plan/OCF-18 dated January 16, 2025, the section 44 independent medical examination dated July 7, 2025, prepared by Dr. David Berbrayer, psychiatrist, and the section 44 independent psychological examination dated March 19, 2025, prepared by Dr. Debra Mandel, psychologist. The applicant also claims that the respondent's denial letter is non-compliant with section 38(8) of the *Schedule*, which requires insurers to provide medical and other reasons why it considered the goods and services not to be reasonable and necessary.
- [9] While I accept the applicant's argument that the applicant was removed from the Minor Injury Guideline ("MIG") limit by the respondent's own determination following the insurer's psychological examination, a removal from the MIG does not automatically entitle the applicant to subsequent treatment plans nor does it render subsequent treatment plans reasonable and necessary. The onus still remains with the applicant to establish that the disputed plan satisfies the statutory test under sections 15 or 16 of the *Schedule*.
- [10] The Tribunal has consistently held that treatment plans alone are insufficient to establish the reasonableness and necessity of the treatment. In this case, the applicant has not submitted contemporaneous clinical notes or treatment records that support the need for ongoing therapy.

- [11] I assign limited weight to Dr. Mandel's section 44 psychological examination report that found that the applicant sustained a psychological impairment as a result of the accident. I am not persuaded by Dr. Mandel's report because it is out of scope for a psychologist to assess the applicant's physical injuries and the report does not consider whether the physiotherapy treatment plan in dispute is reasonable and necessary.
- [12] I assign weight to Dr. Berbrayer's section 44 independent medical examination report. Dr. Berbrayer's examination was conducted approximately 16 months after the accident. Dr. Berbrayer notes that the applicant complains of pain, however, she is independent in all areas of self-care, has resumed work, and is able to drive a vehicle and the disputed treatment plan and further facility-based therapy is not reasonable and necessary.
- [13] The applicant argues the legal test is whether the disputed treatment is necessary for her rehabilitation and achieving maximal recovery, and that Dr. Berbrayer's report is statutorily deficient because it does not complete the essential analysis or evaluation of the disputed treatment, and it does not specifically address whether the applicant has reached maximal recovery.
- [14] I do not accept the applicant's argument that the legal test for determining whether a disputed treatment is reasonable and necessary is based on whether the applicant has achieved maximal recovery. Although Dr. Berbrayer did not explicitly use the term "maximal recovery," I am persuaded by his opinion that the treatment plan is not reasonable and necessary because his report included a comprehensive in-person physical assessment, it indicates that the applicant's injuries have substantially resolved, and it is consistent with the medical evidence before me, such as the clinical notes and records of Dr. Fung, the primary care physician, that notes the applicant was generally well shortly after the accident and that her pain is not as a result of the accident.
- [15] The respondent submits that the applicant has not met the burden of proof to establish, on a balance of probabilities, that the disputed treatment plan is reasonable and necessary. It argues that further facility-based physiotherapy treatment almost one year after the accident is not required and the disputed treatment is inconsistent with the applicant's demonstrated recovery and functional status. Also, the respondent argues that the applicant has not provided independent medical evidence or contemporaneous clinical records from treating providers to support the need for further therapy.
- [16] The respondent relies on the section 44 report prepared by Dr. Berbrayer, the clinical notes and records ("CNRs") of Dr. Gerald Fung, family physician, and the pre-screening report dated April 10, 2024, prepared by Dr. Mehrdad Pojhan, psychologist.

- [17] I find Dr. Fung’s CNRs do not support the applicant’s claim that the physiotherapy treatment is reasonable and necessary. Dr. Fung notes on March 14, 2024, one month after the accident, that the applicant is “generally well” and that the applicant attended for no specific issue. He notes that she has lower back pain, however there is no note of the accident or accident-related pain.
- [18] I place less weight on Dr. Pojhan’s pre-screening report because it is based on the applicant’s subjective complaints, does not include the results of any testing, and it is out of scope for Dr. Pojhan to assess the applicant’s physical symptoms.
- [19] In my view, the independent medical opinion available from Dr. Berbrayer and the CNRs of Dr. Fung found no ongoing impairment requiring further treatment.
- [20] Accordingly, I find that the applicant has not established, on a balance of probabilities, that the OCF-18 dated January 16, 2025, for physiotherapy is reasonable and necessary.

Are the January 24, 2025 and July 8, 2025 denials compliant with section 38(8) of the Schedule?

- [21] I find the respondent’s explanation of benefit letters dated January 24, 2025 and July 8, 2025 are compliant with the requirements under section 38(8) of the *Schedule*.
- [22] Section 38(8) and section 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 10 business days after it receives a treatment plan, of the medical and other reasons why it considered the goods and services not to be reasonable and necessary, if it denies a plan. Pursuant to section 38(11), if an insurer fails to comply with its obligations under section 38(8), it must pay for the goods and services that relate to the period starting on the 11th business day after the insurer received the application and ending on the day the insurer gives a notice described in section 38(8).
- [23] The applicant submits that she disagrees with the denial reasons provided in the denial notices dated January 24, 2025, and July 8, 2025. The applicant submits that the denials are deficient, frivolous, and flawed because they do not include medically/statutorily valid reasons for the denial of the disputed treatment plan. The applicant relies on *Hedley v. Aviva*, 2019 ONSC 5318 (“*Hedley*”), in which the court held that denial reasons must be “meaningful and specific” and “mere boiler plate statements do not provide rationale to which an insured can respond. In essence, such statements constitute no reasons at all.”
- [24] I find the January 24, 2025, letter addresses the date of loss, references the disputed treatment, notes that the injuries fall under the MIG, and advises that a second opinion is needed to assess the reasonableness of the treatment.

- [25] I find the July 8, 2025, letter states, “further treatment is not required at a facility, and she has not had any treatment for several months. The OCF-18 in dispute is not reasonable or necessary.” The letter references Dr. Berbrayer’s section 44 report and notes that her injuries fall within the MIG. Both notices informed the applicant of her right to dispute and, in my view, satisfy the *Schedule’s* requirements.
- [26] I find the explanation of benefits to be compliant with section 38(8) of the *Schedule* because they specifically address the reasons for the denial and are not boilerplate because the respondent lists the specific treatment plan details, the decision not to pay for the treatment, the applicant’s injuries and that additional information is required for treatment.
- [27] In sum, I find the applicant has not established that the respondent’s denial notices, dated January 24, 2025, and July 8, 2025, are non-compliant with section 38(8), and therefore the disputed treatment plan is not payable under section 38(11).

Interest

- [28] Interest applies on the payment of any overdue benefits pursuant to section 51 of the *Schedule*. As no benefits are owed, no interest is payable.

Award

- [29] The applicant sought an award under section 10 of Regulation 664. Under section 10, the Tribunal may grant an award of up to 50 per cent of the total benefits payable if it finds that an insurer unreasonably withheld or delayed the payment of benefits. The Tribunal has determined that an award is justified where the delay or withholding of benefits by the insurer is unreasonable conduct, meaning “behaviour, which is excessive, imprudent, stubborn, inflexible, unyielding or immoderate.” The onus is on the applicant to prove, on a balance of probabilities, that the respondent’s conduct meets this threshold.
- [30] The applicant submits that the disputed treatment was unreasonably denied/withheld and that she is entitled to an award and interest on overdue payments.
- [31] The respondent submits that the applicant failed to discharge her burden of proof and that there is no entitlement to award or interest, and moreover, that there is no evidence the plan was incurred.
- [32] I find that there are no benefits that were unreasonably delayed, denied, or withheld. The evidence shows that the respondent did not act in a manner that is excessive, imprudent, stubborn, inflexible, unyielding or immoderate. The respondent requested a section 44 insurer’s examination and provided compliant denial letters.

[33] Therefore, I find that the applicant has not met the burden of proving that the respondent unreasonably withheld or delayed payment of benefits. As a result, the respondent is not liable for an award.

ORDER

[34] For the above reasons, I order that:

- i. The applicant is not entitled to the treatment plan for physiotherapy services in a plan dated January 16, 2025.
- ii. The treatment plan is not payable pursuant to section 38(8) of the *Schedule*.
- iii. As there is no overdue benefit, the applicant is not entitled to interest.
- iv. The respondent is not liable to pay an award.

[35] The application is dismissed.

Released: June 23, 2026



Aric Bhargava
Adjudicator