Citation: Chan v. Aviva Insurance Company of Canada, 2026 ONLAT 25-004297/AABS

Licence Appeal Tribunal File Number: 25-004297/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:

Sze Man Chan

Applicant

and

Aviva Insurance Company of Canada

Respondent

DECISION

ADJUDICATOR: **Amar Mohammed**

APPEARANCES:

For the Applicant: Rakesh Sharma, Counsel
Sareena Samra, Counsel

For the Respondent: Purva Vaidya, Counsel
Jessica Telfer, Counsel

HEARD: **By Way of Written Submissions**

OVERVIEW

[1] Sze Man Chan, the applicant, was involved in an automobile accident on April 22, 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, 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. Are the applicant's injuries predominantly minor as defined in s. 3 of the *Schedule* and therefore subject to treatment within the $3,500.00 Minor Injury Guideline ("MIG") limit?

ii. Is the applicant entitled to $4,580.08 for Chiropractic services, proposed by Total Recovery Rehab Centre in a treatment plan/OCF-18 ("plan") dated August 28, 2024?

iii. Is the applicant entitled to $2,200.00 for a Psychological Assessment, proposed by Somatic Assessments and Treatment Corp. in a treatment plan dated June 28, 2024?

iv. Is the applicant entitled to $70.00 for doctor's fees, submitted on a claim form (OCF-6) dated March 25, 2025?

v. Is the respondent liable to pay an award under s. 10 of Reg. 664 because it unreasonably withheld or delayed payments to the applicant?

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

RESULT

[3] The applicant is subject to the MIG.

[4] Since the applicant is subject to the MIG, a reasonable and necessary analysis is not required. In addition, the applicant is not entitled to payment for the plans and OCF-6 in dispute.

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

[6] The applicant is not entitled to interest.

ANALYSIS

The applicant is subject to the MIG

[7] I find, on a balance of probabilities, that the applicant's injuries sustained in the accident are predominantly minor as defined by the *Schedule*.

[8] Section 18(1) of the *Schedule* provides that medical and rehabilitation benefits are limited to $3,500.00 if the insured sustains impairments that are predominantly a minor injury. Section 3(1) defines a "minor injury" as "one or more of a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury."

[9] An insured may be removed from the MIG if they can establish that their accident-related injuries fall outside of the MIG or, under s. 18(2), that they have a documented pre-existing medical condition combined with compelling medical evidence stating that the condition precludes recovery if they are kept within the confines of the MIG. The Tribunal has also determined that chronic pain with functional impairment, or a psychological condition, may warrant removal from the MIG. In all cases, the burden of proof is on the applicant.

[10] The applicant refers to s. 54 of the *Schedule* at the outset of submissions to define the burden of proof and scope of this hearing relating to all of the issues in dispute. The applicant's position is that since it is the respondent's denial notice provided under s. 54 from which the dispute before me arises, it follows that if the applicant can overcome the s. 54 denial notice, then the benefits in dispute are deemed reasonable, necessary, and payable, and the applicant is removed from the MIG. The applicant argues:

> Therefore, a trial by written hearing is limited to the applicant's onus to prove on the balance of probabilities that the reasons provided by the respondent in section 54 statutory denial notices were either frivolous, flawed, arbitrary, statutory deficient or no reasons at all, to succeed at the hearing and be entitled to the disputed benefits.

[11] In addition, the applicant's submissions effectively state that he will not argue for permanent removal from the MIG:

> Therefore, MIG applicability gets disputed/ determined not in isolation of a substantive issue, but with respect to the substantive issues and in this

case the following OCF18 is the substantive issue that was denied by the respondent as the MIG applies.

Thus, the applicant will not be making any submissions solely on the applicability of MIG, but will dispute applicability of the MIG with respect to the denied substantive issue.

[12] The applicant does not provide authority for this interpretation of the test for removal from the MIG or the relevance of section 54 of the *Schedule* to the dispute before me. Section 54 provides that if an insurer refuses to pay a benefit or reduces the amount of a benefit that a person is receiving, the insurer shall provide the person with a written notice advising the person of his or her right to dispute the refusal or reduction. The applicant does not allege that the respondent did not fulfill the requirements of s. 54. Accordingly, the applicant has not established the relevance of this section to this dispute. The applicant also argues that that the respondent did not comply with the requirements of s. 38(8) of the *Schedule*. I find that s. 38(8) is relevant but does not provide an avenue for a permanent removal from the MIG.

[13] Since the applicant seeks a determination that she should be removed from the MIG and that the benefits sought are reasonable and necessary, she seeks substantive relief. However, the applicant does not lead substantive arguments or medical evidence in support of this relief sought. Since the onus is on the applicant to establish entitlement, the strength or weakness of the respondent's denial notices, which are the applicant's focus at this hearing, do not assist the applicant in meeting her burden.

[14] For the reasons above, I find on a balance of probabilities that the applicant is subject to the MIG.

The applicant is not entitled to payment of the disputed parts of the plans

[15] I find that the applicant has not established payment of these plans under s. 38 of the *Schedule*.

[16] Section 38(8) requires an insurer to inform an insured person, within 10 business days after it receives the 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 s. 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 s. 38(8)

and it is prohibited from taking the position that the insured person has an impairment to which the MIG applies.

$4,580.08 for Chiropractic services

[17] The applicant's position is that the insurer was required to provide medical and other reasons tied to the injury descriptions listed under Part 6 of the OCF-18. The applicant argues that the denial contains no meaningful medical analysis identifying which injuries or clinical findings place the claim within the MIG, improperly requests documents and compelling evidence not mandated by the *Schedule*, and therefore the denial notice is deficient. The applicant also submits that the respondent did not approve $200.00 for completion of the OCF-18, but did not lead any authority stating a respondent is liable to pay the form completion fee for forms that are denied in full.

[18] The respondent's September 6, 2024, denial of the OCF-18 in the amount of $4,580.08 asserted that the applicant is subject to the MIG limit and that she may substantiate further treatment by asking her doctor to submit some form of compelling evidence addressing removal from the MIG. In addition, the respondent provided reasons that the proposed plan was not reasonable and necessary, asserting that it was excessive and not in line with The Superintendent's Guideline No. 03/14, Professional Services Guideline, ("Guideline") which limits form completion fees to $200.00, and the plan proposed an aggregate of $650.00. Further, that the increased proposed frequency of treatment suggests a decline in the applicant's condition without evidence on file to support it.

$2,200.00 for a Psychological Assessment

[19] The applicant submits the reasons in the June 28, 2024 denial of this plan are deficient because the denial fails to identify which injuries or clinical findings were relied upon, offers boilerplate labels rather than medical analysis, and improperly demands documentary prerequisites not required by the *Schedule*.

[20] The respondent argues it complied with the *Schedule* and provided its reasons to the applicant for denial of this plan. The respondent's June 28, 2024 denial states that the applicant's identified injuries fall within the MIG, that the health professional had not submitted clinical evidence of impairments requiring treatment outside of the MIG, an absence of a psychological referral, and inconsistencies between the treatment plan and the family physician's clinical notes and records. The denial also clearly states that the applicant may provide a copy of the referral for a psychological assessment and the medical information supporting the referral, along with a copy of the pre-screen report and

questionnaire, in order for it to re-consider the denial. The respondent also makes arguments on its position that the plan is not reasonable and necessary, however a s. 38(8) analysis does not require a reasonable and necessary analysis.

Analysis of the denial letters

[21] I find that the June 28, 2024, and September 6, 2024, denials are compliant with s. 38(8) of the *Schedule*. The respondent must include its medical and all other reasons at the time of the denial, but I am mindful that it is not expected that adjusters articulate something resembling a medical opinion or that they be held to a standard of perfection. I am not persuaded by the applicant that the respondent is required to provide a medical analysis of the injuries and sequelae listed in the plan because the respondent is not qualified to complete a medical analysis. I find that the respondent offered a principled rationale based fairly on the applicant's file satisfying its obligation to provide sufficient reasons including citing the MIG and requesting evidence from the applicant to support removal from the MIG.

[22] The respondent also fairly addressed its opinion that the plan for chiropractic services was excessive and provided clear reasons for that opinion. This denial also provided a specific and reasonable request for information and addressed the specific details of the plan in concluding it was also not reasonable and necessary.

[23] Under the circumstances, the respondent's references to the definition of a minor injury and the MIG limit are the specific details about the applicant's condition that the respondent was able to engage with. Read together, the denial notices provide adequate reasons to allow an unsophisticated person to understand them and make an informed decision to either accept or dispute the denials.

[24] For the reasons above, on a balance of probabilities, I find that the applicant has not established payment of these plans under s. 38 of the *Schedule*.

$70.00 in doctor fees claimed on an OCF-6

[25] I find that the applicant is not entitled to the partial payment of this OCF-6.

[26] The applicant submits that if she is removed from the MIG then the balance of this OCF-6 should be payable. However, I have found that the applicant is subject to the MIG.

[27] Therefore, I find that the applicant is not entitled to the partial payment of this OCF-6.

Interest

[28] Interest applies on the payment of any overdue benefits pursuant to s. 51 of the *Schedule*. Since there are no overdue benefits, the applicant is not entitled to interest.

Award

[29] The applicant sought an award under s. 10 of Reg. 664. Under s. 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. Since there are no unreasonably withheld or delayed payments of benefits, the respondent is not liable to pay an award.

ORDER

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

i. The applicant is subject to the MIG.

ii. Since the applicant is subject to the MIG, a reasonable and necessary analysis is not required. In addition, the applicant is not entitled to payment for the plans and OCF-6 in dispute.

iii. The respondent is not liable to pay an award.

iv. The applicant is not entitled to interest.

Released: July 9, 2026

Amar Mohammed
Adjudicator