Citation: Niezbrzycki v. Economical Mutual Insurance Company, 2024 ONLAT 22-006046/AABS

Licence Appeal Tribunal File Number: 22-006046/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:

Hilda Niezbrezycki

Applicant

and

Economical Mutual Insurance Company

Respondent

DECISION

VICE-CHAIR: **Jeremy A. Roberts**

APPEARANCES:

For the Applicant: Hilda Niebrzycki, Applicant
Joshua Lindzon, Counsel

For the Respondent: Economical Mutual Insurance Company
Nivedita Misra, Counsel

HEARD: **In Writing**

OVERVIEW

[1] Hilda Niebrzycki, the applicant, was involved in an automobile accident on January 27, 2020, 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, Economical Mutual Insurance Company, and applied to the Licence Appeal Tribunal - Automobile Accident Benefits Service (the "Tribunal") for resolution of the dispute.

PRELIMINARY ISSUES

[2] The preliminary issues are:

i. Is the applicant statute-barred from proceeding with the issue of non-earner benefits ("NEBs") and the treatment plans listed as items 3(3) and 3(6) below, due to the two-year limitation period in s. 56 of the *Schedule*?

ii. Is the applicant barred from proceeding with the issue of NEBs because the applicant failed to complete the Election of Benefits form ("OCF-10") to make an election?

iii. Is the applicant barred from proceeding with the issues of the Minor Injury Guideline ("MIG") and the treatment plans in dispute, as the applicant has failed to submit a Treatment Confirmation form ("OCF-23") in accordance with s. 40 of the *Schedule*?

SUBSTANTIVE ISSUES

[3] The substantive 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 MIG limit?

ii. Is the applicant entitled to a NEB of $185.00 per week from February 24, 2020 to January 27, 2022?

iii. Is the applicant entitled to $2,984.87 for chiropractic services, proposed by Mount Dennis Weston Physiotherapy and Chiropractic Centre in a treatment plan/OCF-18 ("plan") submitted January 31, 2020?

iv. Is the applicant entitled to $2,460.00 for a neurological assessment, proposed by Alliance Plade Medical in a treatment plan submitted March 15, 2022?

v. Is the applicant entitled to $2,200.00 for an occupational therapy ("OT") assessment, proposed by PIOT in a treatment plan submitted May 12, 2022?

vi. Is the applicant entitled to $2,486.00 for a psychological assessment, proposed by Mount Dennis Weston Physiotherapy and Chiropractic Centre in a treatment plan submitted February 12, 2020?

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

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

ix. Is the applicant entitled to costs pursuant to Rule 19 of the Licence Appeal Tribunal Rules (2023) ("LAT Rules")?

RESULT

[4] The applicant is barred from proceeding with the issue of NEB because she failed to complete the OCF-10.

[5] The applicant is barred from proceeding with issues 3(iii) and 3(vi) because she failed to submit the required OCF-23.

[6] The applicant is subject to the MIG.

[7] The applicant is not entitled to the proposed OT assessment.

[8] The applicant is entitled to the proposed neurological assessment, along with interest for this plan, subject to remaining funds available within the MIG.

[9] The applicant is not entitled to an award or costs.

ANALYSIS

The applicant is not statute barred from proceeding with any of the issues in dispute due to the two-year limitation period

[10] The applicant is not statute barred from proceeding with her claim for NEBs or the treatment plans listed as 3(iii) and 3(vi) above because she appealed the treatment plans within the extended limitation period.

[11] Section 56 of the *Schedule* states that any application "in respect of a benefit shall be commenced within two years after the insurer's refusal to pay the amount claimed." That said, O. Reg. 73/20: *Limitation Periods* suspended the limitation period during the COVID-19 pandemic, effectively adding 183 days to the limitation period for appeals.

[12] The applicant argued that the items in dispute were appealed within the extended limitation period granted by O. Reg. 70/20. The respondent argued that in order to be eligible for the extended limitation period, the applicant must satisfy the Tribunal that the delay in appealing was a direct result of the COVID-19 pandemic, which it contends she did not do in this case.

[13] I agree with the applicant and do not find that the language in O. Reg. 70/20 supports the position advanced by the respondent. I find that the limitation periods were extended by 183 days, meaning that the applicant submitted her appeals within the extended time frame. The applicant is not statute barred from disputing these items.

The applicant is statute-barred from proceeding with the issue of NEB because she failed to submit an OCF-10

[14] The applicant is statute barred from proceeding with her claim for NEBs because she failed to submit the required OCF-10 within the 30 days required in the *Schedule*.

[15] Section 35(1) of the *Schedule* indicates that "if an application indicates that the applicant may qualify for two or more of the income replacement benefit ("IRB"), the NEB and the caregiver benefit under Part II, the insurer shall, within 10 business days after receiving the application, give a notice to the applicant advising the applicant that he or she must elect, 30 days after receiving the notice, the benefit he or she wishes to receive."

[16] In this case, the applicant submitted an OCF-3 on February 12, 2020. On February 13, 2020 the insurer advised the applicant that she would be required to complete an OCF-10 in order to determine which benefit she intended to apply for. On February 28, 2020 the applicant emailed the insurer to indicate that the applicant "returned to work within the one week deductible period" and as such was "not entitled to IRBs". As such, the applicant declined to submit an OCF-10. On March 31, 2023 an OCF-10 was submitted.

[17] The applicant argued that because she emailed the respondent on February 28, 2020 and confirmed that she returned to work within the one week deductible

period she was “not entitled to IRBs” and “an OCF-10 was not required”. She argues that a request for an OCF-10 is only appropriate when there is inconsistent information given in the OCF-1 or OCF-3, which she argues wasn’t the case here.

[18] The respondent argued that the applicant failed to adhere to her responsibilities under s. 35(1) of the *Schedule* and that the applicant’s email of February 28, 2020 did not negate the necessity for an OCF-10 because the applicant is not automatically disentitled to an IRB because she is working.

[19] I agree with the respondent and find that the applicant was required by s. 35(1) to submit an OCF-10 within 30 days electing the benefit she wished to receive. As the respondent noted, the applicant’s ability to work does not automatically disentitle her from an IRB because the test following the accident is not that they have a “complete inability” to work, but rather than they have a “substantial inability”. This leaves ambiguity that should be corrected through the appropriate process of filing an OCF-10. I am also not satisfied that the applicant submitted an OCF-10 well over three years following the accident as this falls well-outside of the 30 day time period.

[20] I find that the applicant is statute barred from proceeding with their claim for NEB.

The applicant is barred from proceeding on issues 3(iii) and 3(vi) because she failed to submit OCF-23s

[21] The applicant is barred from proceeding on issues 3(iii) and 3(vi) because she failed to submit the requisite OCF-23s. The applicant can proceed with her case on issues 3(i), 3(iv) and 3(v) because I find no evidence that the respondent requested OCF-23s.

[22] Section 38(5) of the *Schedule* states that an insurer may refuse to accept a treatment and assessment plan if the plan describes goods or services to be received or an assessment or examination to be conducted 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. Section 38(6) then states that an insurer’s refusal to accept a treatment and assessment plan under ss. (5) is final and not subject to review.

[23] When subject to the MIG, insureds are required to submit treatment through OCF-23s and not OCF-18s, in order to access the initial block of treatment funding. This legislative prohibition is designed to ensure that insureds exhaust

the funding in the MIG or are removed from the MIG before receiving treatment beyond the $3,500.00 limit.

[24] The applicant argues that none of the denial letters were made pursuant to sections 38(5) and 38(6) of the *Schedule* and thus the request for an OCF-23 is not grounds to bar the applicant from proceeding on these issues. The respondent argues that because the treatment plans were denied on the basis that the applicant was still under the MIG, they are subject to the requirements under s. 38(5) and the decisions are final and not reviewable.

[25] In considering the evidence, I find that the denials of issues 3(iii) and 3(iv) were properly made under s. 38(5) of the *Schedule* and thus the applicant is barred from disputing their denials. In the denial letters for both treatment plans the insurer explicitly states that the treatment plans are denied because the applicant's injuries appear to be predominantly minor and the insurer requests that the applicant "submit an OCF-23 Treatment Confirmation Form for completion of your file and funding approval". If the applicant submits the requested OCF-23, the respondent will be required to fund the treatment up to the MIG limit.

[26] However, I do not see evidence in either document brief of a formal request for the applicant to submit an OCF-23 for the treatment plans outlined in issues 3(v) and 3(vi). Without this evidence, I cannot make a finding on the preliminary issue and am thus allowing these issues to proceed, along with the dispute of whether the applicant falls under the MIG.

The applicant is subject to the MIG

[27] I find that the applicant is subject to the MIG because I do not find that her injuries fall outside the MIG or satisfy any of the exceptions.

[28] 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 sequalae to such an injury."

[29] An insured may be removed from the MIG if they can establish that their accident-related injuries fall outside the MIG or, under s.18(2), that they have a documented pre-existing injury or 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 a psychological condition may warrant removal from the MIG. In all cases, the burden of proof lies with the applicant.

[30] The applicant argues that she should be removed from the MIG based on: (1) her concussion diagnosis, which falls outside the definition of "minor injury"; (2) her psychological injuries; and (3) her pre-existing knee and shoulder injuries.

i. On (1), her concussion diagnosis, the applicant supports this via records of Humber River Hospital which show that she was diagnosed with a concussion after the accident and through the records of Dr. Jha, a neurologist who conducted a s. 25 assessment, who found that the records support a mild-traumatic brain injury diagnosis and subsequent impairments that require treatment outside the MIG.

ii. On (2), the applicant's psychological injuries, she relies on the family doctor records, which show her being diagnosed with PTSD-type symptoms, anxiety and depression for which she was prescribed Cipralex, alongside a diagnosis from Social Worker Fiorillo of adjustment-like disorder. The applicant notes that she has experienced nervousness driving and was having nightmares every night about the car accident.

iii. On (3), the applicant alleges pre-existing knee and shoulder injuries, but beyond references to her medical documentation, the applicant does not make further submissions on why these pre-existing injuries merit removal from the MIG.

[31] The respondent argues that none of the impairments described by the applicant rise to the level of removal from the MIG.

i. On point (1), the applicant's alleged concussion, the respondent argues that the records of Humber River Hospital state that the applicant suffered a "likely mild concussion", but that there was no reported loss of consciousness to the hospital, no recommendations for follow-up treatments, no further assessments for the concussion, and no significant complaints of any post-concussive issues. It argues that Dr. Jha did not review many medical records and relied heavily on the applicant's subjective reporting, which means that his findings on the applicant's concussion are of little value. Lastly, the respondent argued that it is generally accepted that in order to escape the MIG the applicant must present with both a concussion and post-concussive symptoms.

ii. On point (2), the applicant's psychological diagnoses, the respondent argues that there has been no psychological treatment since the accident and that the severity of the diagnoses advanced by the applicant do not support her level of impairment, given that the applicant returned to work shortly after the accident and was able to complete her job and drive to and from work without difficulties. Moreover, it argues that the findings of Dr. Langis, the applicant's assessing psychologist, were not based on medical documentation but instead on the applicant's self-report, leaving us with little medical documentation to support the applicant's case.

[32] In considering the evidence, I do not find that the applicant has met her onus in demonstrating that her injuries fall outside the MIG.

i. On issue (1), the applicant's concussion, I find that there is not enough objective medical evidence to support a diagnosis of a concussion. The hospital records notes a "likely" mild concussion, which in my view does not constitute a formal diagnosis. Given this, I am also not satisfied with Dr. Jha's conclusion that the applicant suffered a mild traumatic brain injury which has since resolved, as I see little medical evidence to support this diagnosis based on established criteria.

ii. On issue (2), the applicant's psychological injuries, I am also not convinced that the applicant has provided sufficient medical evidence to support a claim that her psychological injuries place her outside the MIG. Despite reporting psychological symptoms to several clinicians, beyond medication she has not sought treatment from a specialist. Moreover, while she places particular emphasis on her fear of driving and being in a car, she has continued to keep up a busy job as a nanny and regularly drives to work. I find that I am not convinced that the applicant's psychological symptoms amount to an impairment sufficient to merit her removal from the MIG.

iii. On issue (3), the applicant's pre-existing injuries, I am unsatisfied by the lack of submissions from the applicant as to why these pre-existing injuries would meet the high bar for removal from the MIG. I find that I am not convinced that these merit her removal from the MIG.

[33] I find that the applicant is subject to the MIG.

The applicant is not entitled to the proposed OT assessment

[34] I find that the applicant is not entitled to the proposed OT assessment because I do not find that the treatment plan is reasonable and necessary.

[35] The case conference report and order indicated that the MIG limits of $3,500.00 had not yet been exhausted. However, neither party commented on this in their submissions. Based on the case conference report and order, I will conduct an analysis of the treatment plans in dispute.

[36] The issue in dispute is a medical and rehabilitation benefit. Sections 14 and 15 of the *Schedule* state that an insurer shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident.

[37] The applicant bears the onus of providing on a balance of probabilities that the claimed medical benefits are reasonable and necessary and that the impairments are accident related. In order to do so, an applicant should establish that the treatment goals are reasonable, that the goals are being met to a reasonable degree, and that the overall cost of achieving the goals is reasonable.

[38] The applicant argued that the proposed OT assessment was reasonable and necessary on the basis that she has experienced difficulties completing her activities of daily living. She argued that the assessment would help her obtain recommendations for further treatment or investigations.

[39] The respondent argued that the proposed OT assessment was not reasonable and necessary because, by the applicant's own affidavit, she was fully independent in her activities of daily living. Moreover, not only was she independent in these activities, she provided these services to others through her employment as a nanny.

[40] I find that the applicant has not met her onus in demonstrating that the proposed OT assessment is reasonable and necessary. I agree with the respondent that the applicant herself indicates independence in her activities of daily living and her ability to continue her job full time after the accident serves to reinforce this point. The applicant is not entitled to the proposed OT assessment.

The applicant is entitled to the proposed neurological assessment

[41] I find that the applicant is entitled to the proposed neurological assessment as the goals of the assessment are reasonable and necessary.

[42] The case conference report and order indicated that the MIG limits of $3,500.00 had not yet been exhausted. However, neither party commented on this in their submissions. Based on the case conference report and order, I will conduct an analysis of the treatment plans in dispute.

[43] The test for entitlement is the same as the test for the previous treatment plan.

[44] The applicant argued that given her concussion diagnosis post-accident as well as complaints of head aches and dizziness, it is reasonable and necessary for a neurological assessment to be conducted so that appropriate treatment could be recommended if necessary. She argued that the assessment would help her obtain recommendations for further treatment or investigations.

[45] The respondent argued that the applicant was never diagnosed formally with a concussion or post-concussive symptoms and that because of this, she has failed to demonstrate why a neurological assessment is reasonable and necessary.

[46] I agree with the applicant. While I acknowledge that the applicant was never formally diagnosed with a concussion, the post-accident hospital records that suggest a “likely mild concussion” provide a solid basis for further investigation. It is not unreasonable in such scenarios and given other reported symptoms to undertake an assessment for further clarity (regardless of whether such an assessment finds treatment merited or not). I find that the applicant has met her onus in demonstrating that a neurological assessment is reasonable and necessary.

[47] Subject to amounts remaining in the MIG, the applicant is entitled to the proposed neurological assessment.

The applicant is owed interest on the OT assessment plan

[48] Interest applies on the payment of any overdue benefits pursuant to s. 51 of the *Schedule.* The applicant is owed interest on the neurological assessment.

The applicant is not entitled to an award

[49] 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.

[50] The applicant argued that she is entitled to a 50% award of all the denied treatment plans and NEBs. She argued that the insurer unreasonable withheld or

delayed payments owed by being inflexible in its conduct and by ignoring medical information it had on file.

[51] The respondent argued that it behaved reasonably by responding to the OCF-18s in a timely fashion and attempting to schedule IEs as necessary.

[52] I find that the applicant is not entitled to an award in this case. I find that the respondent acted reasonably and in accordance with the *Schedule*. The proper processes were followed.

The applicant is not entitled to costs

[53] I find that the applicant is not entitled to costs.

[54] Rule 19.1 provides that a party may request costs of the proceeding if they believe that the other party has acted unreasonably, frivolously, vexatiously, or in bad faith during the proceedings. Rule 19.4 further sets out the requirements for that request, which must include the reasons for the request and the particulars of the alleged conduct. The purpose of Rule 19.1 is to deter conduct by parties that is unreasonable, frivolous, vexatious, or in bad faith. This is a high bar for conduct that attracts a costs award and is an exceptional remedy. Rule 19.6 sets out of the maximum amount of costs, which shall not exceed $1,000.00 for each full day of attendance at a hearing.

[55] The applicant argued that costs of $2,000.00 were appropriate because the respondent acted in bad faith throughout the proceedings. Specifically, it argued that the respondent scheduled "11th hour insurer examinations" and "claimed to have not received clinical notes and records despite confirmation of payment of these records from the insurer." She argued that costs should be awarded to discourage this type of behaviour in the future.

[56] The respondent made no submissions regarding the applicant's claim for costs.

[57] I find that there is no compelling evidence to prove that the respondent behaved unreasonably, frivolously, vexatiously, or in bad faith. The respondent followed the requirements of the *Schedule* in adjusting this claim and none of their behaviour meets the high bar set for a claim for costs. The applicant is not entitled to costs.

ORDER

[58] I order the following:

i. The applicant is barred from proceeding with the issue of NEB because she failed to complete the requisite OCF-10.

ii. The applicant is barred from proceeding with issues 3(iii) and 3(vi) because she failed to submit the required OCF-23.

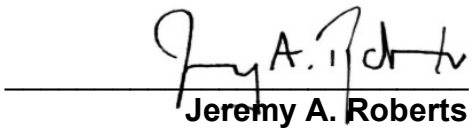
iii. The applicant is subject to the MIG.

iv. The applicant is not entitled to the proposed OT assessment.

v. The applicant is entitled to the proposed neurological assessment, along with interest for this plan, subject to remaining funds available within the MIG.

vi. The applicant is not entitled to an award or costs.

Released: May 27, 2024



Jeremy A. Roberts
Vice-Chair