**Citation: Wang v. CAA Insurance Company, 2025 ONLAT 23-013717/AABS**

**Licence Appeal Tribunal File Number: 23-013717/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:

**Joy EnLe Wang**

**Applicant**

and

**CAA Insurance Company**

**Respondent**

# DECISION

**ADJUDICATOR:** **Roderick Walker**

**APPEARANCES:**

For the Applicant: Rakesh Sharma, Counsel

For the Respondent: Michelle Qiu, Counsel

**HEARD:** **By Way of Written Submissions**

## OVERVIEW

[1] Joy EnLe Wang, the applicant, was involved in an automobile accident on May 4, 2022, 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, CAA 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. Are the applicant's injuries 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 $4,217.20 for chiropractic services, proposed by U Heal in a treatment plan/OCF-18 ("plan") submitted September 27, 2022?

iii. Is the applicant entitled to $2,200.00 for a psychological assessment, proposed by Somatic Assessments and Treatment Clinic in a plan submitted June 20, 2022?

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

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

## RESULT

[3] The applicant's injuries are minor as defined by s. 3 of the *Schedule* and as such the applicant remains in the MIG.

[4] The plans identified as issues ii- iii are payable once incurred.

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

## ANALYSIS

### *MIG*

[6] 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 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.”

[7] 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 injury or condition combined with compelling medical evidence stating that the condition precludes recovery if they are kept within 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 lies with the applicant.

[8] The applicant in this case submits that she should be removed from the MIG on the basis of a psychological impairment.

### ***The applicant does not suffer from a Psychological Impairment that would remove her from the MIG.***

[9] I find that the applicant does not suffer a psychological impairment which warrants her from the MIG.

[10] The applicant submits a plan with the above injuries and sequelae as noted in paragraph 9 in the OCF-18. he applicant’s psychological injuries are phobias, nightmares, sleep disorders, anger, irritability, and fatigue.

[11] I reiterate that it is the applicant's onus to prove on a balance of probabilities that his psychological injuries do not fall within the MIG. In this case the applicant has a family doctor, Dr. K. Tung, G.P. and as I review his notes, it does not reveal a psychological complaint or symptom that was the result of the accident. The applicant also has evidence of a s. 25 assessment by Dr. S. McDowall, psychologist, which indicated on the disputed plan that the applicant has self reported her injuries such as sleeping issues, travelling, and avoiding driving. I find that Dr. McDowall did not review any medical records/history of the applicant. Further, Dr. McDowall did not render any DSM-5 diagnosis or psychological impairments or indicate what tests (if any) were administered during her assessment.

[12] The applicant makes references to her psychological injuries but fails to argue or establish that they were significant enough to remove her from the MIG. I find the applicant has not met her onus in on a balance of probabilities that she should be removed from the MIG for her psychological injuries.

[13] I have determined the applicant's injuries fall within the MIG, I must still determine if the applicant is entitled to the disputed OCF-18's as she argues the denials were deficient.

**Treatment Plans**

[14] In terms of the sufficiency of the denials, the applicant argues that the denial notices issued by the respondent do not comply with the requirements of section 38(8) of the *Schedule.*

[15] Section 38(8) requires an insurer to inform an insured person, within ten 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 a impairment to which the MIG applies.

[16] The respondent asserts that the denials are complaint with the *Schedule*. The respondent argues that it is sufficient for the denials to say that the applicant's injuries fall within the MIG, particularly because it had little medical documentation to refer to or base its reasons on. The respondent points out the applicant submitted, the disputed OCF-18s without corroborating evidence to support her claim. As a result, of the limited amount of medical documentation provided by the applicant, the respondent submits that its medical reasons were sufficient. I do not agree.

[17] The standard for sufficient notice is contained in *T.F. v. Peel Mutual Insurance* Company, 2018 CanLII 39373 (ON LAT), In her decision, Executive Chair Lamoureux states, at paragraph 19:

> […] an insurer's "medical and any other reasons" should, at the very least, include specific details about the insured's condition forming the basis for the insurer's decision or, alternatively, identify information about the insured's condition that the insurer does not have but requires. Additionally, an insurer should also refer to the specific benefit or determination at issue, along with any section of the Schedule upon which it relies. An insurer's "medical and any other reasons" should be clear and sufficient enough to allow an unsophisticated person to make an informed decision to either accept or dispute the decision at issue. Only then will the explanation serve the Schedule's consumer protection goal.

[18] I have reviewed each of the denials provided by the respondent and find they do not meet the standard set in T.*F. v Peel Mutual Insurance Company*. The June 23, 2022, denial of the OCF-18 for $2,200.00, prepared by Dr. S. McDowell dated June 23, 2022, states ""Please accept the correspondence as confirmation that, in accordance with Section 38(8) of the Statutory Accident Benefits Schedule we do not agree to fund the OCF 18 for the following reasons: "Declined per section 38(5) of the Statutory Accident Benefits Schedule. Please have your Health Practitioner submit compelling medical evidence for our review and considerations."

[19] The October 13, 2022, denial of the OCF-18 for $4,217.20 for chiropractic services, proposed by U Heal in a treatment plan/OCF-18 ("plan") submitted September 27, 2022, states, "Declined per section 38 3(c, b) of the Statutory Accident Benefits Schedule, no medicals on file, 2nd opinion required, awaiting insurer examination reports, upon receipt of these reports, we will revisit this treatment plan."

[20] I find all the denials provided for the OCF-18s are identified as issues ii-iii do not comply with s. 38(8) of the Schedule. The denials do not clearly refer to the medical documents the respondent reviewed in reaching its decision. They also fail to identify any information about the applicant's condition despite this information being provided in the initial plans submitted by the applicant. For these reasons, I find that the denials do not meet the minimum standard required by the *Schedule* and the case law.

[21] The denial of the June 23, 2022, states that the respondent is relying on s. 38(5) of the Schedule and requires the applicant's health practitioner submit compelling medical evidence. This is a conclusion rather than a medical reason. The respondent failed to provide any context or explanation for how it came to this conclusion or provide any context as it why it was relevant to its decision. The information provided by the respondent was therefore not sufficient to enable an unsophisticated person to understand the denial or to decide whether to dispute it.

[22] The respondent also fails to tell the applicant what information it needs to accurately assess whether the applicant's injuries fall outside the MIG. The denial letter of June 23, 2022, states that it awaits CNRs from the applicant's medical practitioner, it does not however make a specific request for those records or provide an explanation as it why the CNRs are relevant or necessary for the respondent to makes it determination. Again, I find this does not meet the minimal standard set out in *T.F. v. Peel Mutual Insurance Company*, as it is something that an unsophisticated person would not be able to understand.

[23] I also find in respect to the October 13, 2022, denial letter that the respondent received the disputed OCF-18 on September 27, 2022; however, it sent the denial letter to the applicant October 13, 2022, which is one business days. The respondent is non complaint with s. 38(8) where the respondent is required to serve the denial letter ten business days or sooner to the applicant.

[24] I also find that in the denial dated, October 13, 2022, the respondent fails to provide medical reasons for the denial and requests a 2nd opinion but fails to provide a specific request for what medical records or provide an explanation as to why the additional medical records or a 2nd opinion is required. Again, I find this does not meet the minimal standard set out in T.*F. v. Peel Mutual Insurance Company*, as it is something that an unsophisticated person would not be able to understand.

[25] In summary, I find that the OCF-18s listed as issues ii-iii are payable once incurred, due to the respondent's non-compliance with s. 38(8) of the *Schedule*.

***Interest***

[26] Interest applies on the payment of any overdue benefits pursuant to s. 51 of the *Schedule*.

***Award***

[27] The applicant sought an award under s. 10 of Reg. 664 because the respondent failed to provide the necessary medical reasons for denying the disputed OCF-18s. Under section 10, the Tribunal may grant an award of up to 50 per cent of the total benefits payable if it finds that the unreasonably withheld or delayed the payment of benefits. I find in this case that the respondent did not reasonably delay or hold any benefits to the applicant, so I am not prepared to grant the applicant an award.

**ORDER**

[28] I find on the totality of the evidence that:

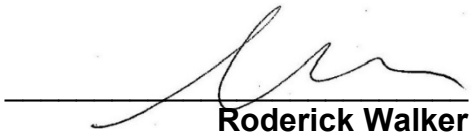
i. The applicant's injuries fall within the MIG.

ii. I order that the plans identified as issues ii- iii are payable once incurred as I find the respondent's denials did not comply with s. 38(8) of the *Schedule*.

iii. Interest is payable on the plans ii-iii under s. 51 of the *Schedule.*

iv. The Respondent is not liable to pay an award.

**Released: September 19, 2025**



**Roderick Walker**
**Adjudicator**