ACTION NO: SC-17-9459

TORONTO SMALL CLAIMS COURT

BETWEEN:

TORONTO HEALTH CARE CLINIC INC.

PLAINTIFF

AND

SARDER ELIUS SADIQUE

DEFENDANT

FOR THE PLAINTIFF: *J. HEWLETT*

FOR THE DEFENDANT: *R. MAHAVALIRAJAN*

JUDGMENT AND REASONS FOR JUDGMENT

[1] This action was called for trial on February 14, 2022 but adjourned on consent to May 25,2022. Trial was held on May 25 and June 20, 2022 with closing argument heard on June 30, 2022. Judgment was reserved to these written reasons.

[2] The plaintiff claims payment of $7,758.67 for physiotherapy services provided to the defendant. Invoices for the $7,758.67 claimed (referred to collectively as the "Unpaid OCF21s") are all dated and all sent to the defendant's accident benefit insurer before May 2011.

[3] The plaintiff sues for breach of contract alleging that the defendant promised to pay for the therapy in the event that the insurer declined to do so. While paragraphs 1 d, e and f of the Claim seek various items of declaratory relief and findings of breach of trust, those claims are

not being advanced. It is agreed that no amount was received by the defendant from the insurer for the Unpaid OCF21's.

[4] The defendant admits that services on the dates and in the amounts pleaded were provided and raises only one defence. That defence is that the claim was brought outside the two- year period prescribed under the *Limitations Act*. But for this lone defence liability is admitted. This Court does not, therefore, rule on the interpretation of the payment clause relied on.

[5] The short history of the dispute is as follows. The defendant was in a motor vehicle accident on November 4, 2010. A tow truck driver referred the defendant to the plaintiff's clinic. Later, the plaintiff referred the defendant to a law firm. Later, that law firm appears to have done some legal work on behalf of the defendant (more on this below). Between November of 2010 and April of 2011, the defendant received accident- related treatments at the plaintiff's clinic.

[6] Before starting these treatments, the defendant signed various documents prepared by the plaintiff. Included were plans called "treatment plans" or OCF18's. The OCF 18's provided as follows respecting payment, part 10, by the defendant:

> *If I undertake any of the proposed services prior to approval by the insurer, I may be responsible for payment to my provider for any of the services rendered on my behalf.*

A second document signed by the defendant was called an AUTHORIZATION AND DIRECTION CONSENT. This document provided *inter alia* as follows:

> *I further authorize and consent the Insurers to mail or deliver all payments for the above noted services payable to Toronto HealthCare Inc. pursuant to O.Reg 403/96 section 44(2) (c) . It is further agreed if the Insurer makes payment directly to the Insured [here the defendant], the Insured will make full payment to Toronto HealthCare Inc. within seven (7) days of payment. Failure to make payment within seven (7) business days to Toronto HealthCare Inc. will result in additional charges of a $100 administrative fee and 18% interest compounded monthly on the account.*
>
> *Further, I authorize and consent Toronto HealthCare Inc. to directly bill my Collateral Insurer.*

[7] In due course, various invoices for the treatment, called OCF 21's, were sent by the plaintiff to the defendant's insurer TD Insurance. TD partially approved and paid the plaintiff for part of the first OCF 21 and ultimately paid to the plaintiff up to $1,800 of the sums invoiced but the $7,758.67 balance was not approved and paid by the insurer and this balance is sued for here. As between the plaintiff and another treatment provider, however, a total of $3,500 was paid in accident benefits.

[8] The unpaid balance has been outstanding under invoices delivered to the insurer since at least May 2011, the last of the OCF 21's having been delivered to the insurer in April of 2011 and 30 days being described in the evidence as the presumptive review period by the insurer.

[9] On March 10, 2017 the plaintiff wrote to the defendant making "formal" demand for payment of the outstanding OCF21's:

> *We write to advise that our office has yet to receive payment for the services which were provided to you following your motor vehicle accident which occurred on November 4, 2010.*
>
> *Please note that the amount of $7,758.67 payable to our office for diagnostic/therapy services provided to you remains outstanding to date. Interest on the outstanding amount continues to accrue. ...*
>
> *Please treat this correspondence as our formal demand for immediate payment of the amount of $7,758.67 plus interest.*
>
> *Should payment in full not be received within 14 days of today's date, we will be commencing a Court action against you for payment of all outstanding amounts along with interest and legal expenses on a substantial indemnity basis plus HST. [underlining added]*

[10] The letter was followed by a further demand for payment on April 24, 2017 and the commencement of this action on September 7, 2017.

[11] The defendant argues that the action was commenced well outside the two- year period. The plaintiff argues that the issue is to be resolved according to the discovery rules laid down in *Section 5(1)* of the *Limitations Act* and that the plaintiff could not reasonably been expected to be aware that an action for payment against the defendant would be an appropriate means of redress for the alleged breach of contract until at least November 2, 2015.

[12] November 2, 2015 is the date on which an enquiry was made by the plaintiff of TD Insurance about the status the insurer's intentions to pay the outstanding balance. As the plaintiff's representative put the point in argument: *"this is the point where there is no information that the file [a file whereby the defendant through legal counsel was pursuing recovery against the insurer for the unpaid balance] is ongoing"*. Accordingly, it is at this point that the plaintiff says it would have been put on notice that the insurer was not going to change its position on the denial of coverage first communicated in 2011.

[13] The plaintiff submits that between May 2011 and November 2, 2015 the plaintiff reasonably assumed that the insurer might reverse its position and decide to pay the outstanding balance such that a collection action against the defendant would be unnecessary. The plaintiff cites Sub-section 5 (1) (a) (iv) of the Act.

[14] The relevant provisions of the Act are as follows:

> ***4*** *Unless this Act provides otherwise, a proceeding shall not be commenced in respect of a claim after the second anniversary of the day on which the claim was discovered. 2002, c. 24, Sched. B, s. 4*
>
> ***5*** *(1) A claim is discovered on the earlier of,*
>
> *(a) the day on which the person with the claim first knew,*
>
> *(i) that the injury, loss or damage had occurred,*
>
> *(ii) that the injury, loss or damage was caused by or contributed to by an act or omission,*
>
> *(iii) that the act or omission was that of the person against whom the claim is made, and*
>
> *(iv) that, having regard to the nature of the injury, loss or damage, a proceeding would be an appropriate means to seek to remedy it; and*
>
> *(b) the day on which a reasonable person with the abilities and in the circumstances of the person with the claim first ought to have known of the matters referred to in clause (a). 2002, c. 24, Sched. B, s. 5 (1).*
>
> *(2) A person with a claim shall be presumed to have known of the matters referred to in clause (1) (a) on the day the act or omission on which the claim is based took place, unless the contrary is proved. 2002, c. 24, Sched. B, s. 5 (2).*
>
> *(3) For the purposes of subclause (1) (a) (i), the day on which injury, loss or damage occurs in relation to a demand obligation is the first day on which there is a failure to perform the obligation, once a demand for the performance is made. 2008, c. 19, Sched. L, s. 1.*
>
> *(4) Subsection (3) applies in respect of every demand obligation created on or after January 1, 2004. 2008, c. 19, Sched. L, s. 1.*

[15] Having carefully considered the evidence and the very able and thorough arguments made on behalf of both parties, I find that the action was commenced outside the two- year period prescribed by the Act and I hereby dismiss the Claim. My reasons for arriving at that determination are set out below

The Limitation Defence

[16] In assessing the limitation defence, three facts fall to be determined: (1) when did the act or omission sued for take place; (2) when did the plaintiff learn of this act or omission; and (3) when did a lawsuit against the defendant become an appropriate means of redress?

When did the act or omission take place?

[17] For an action directed to collection of various invoices, it is no small oddity that the invoices- the OCF 21's sent to the insurer- contain no express due date. Rather the invoices state as follows: "The Insurer shall pay interest on overdue outstanding balances as required by the Statutory Accident Benefits Schedule." The standard period for review and payment by the insurer was identified by the plaintiff's witness Ms. Ribatachok as 30 days.

[18] Impliedly then 30 days after the date of the OCF 21's would be a "due date" for the insurer for any invoices if related to approved treatment. The last OCF 21 at issue was dated April, 2011. 30 days thereafter would put the due date for the insurer at or about the end of May 2011.

[19] Consistent with there being a 30 days due date, the insurer paid interest to the plaintiff on OCF 21 dated December 15, 2010. As the insurer's representative Ms. Cullingford explained $4 in interest paid as paid on that OCF 21 because the payment was not made by on its "due date" of January 15, 2011.

[20] There is no written deadline for payment by the defendant insured other than in the event that the defendant received benefits directly from the insured respecting any OCF21's. The Authorization and Direction form requires those funds to be passed on to the plaintiff within seven days and provides for a rate of interest for any delay.

[21] It is not disputed that copies of the unpaid OCF 21's were provided to the defendant in and before the end of 2012 in several forms. The plaintiff asserts, per the March 10, 2017 letter, that the unpaid invoices were sent to the lawyer for the defendant on February 23, 2012. In addition, notice that each of the unpaid OCF 21's were not being approved for payment by the insurer was given to the defendant and his then lawyer by TD. Letters dated April 15 and

February 18, 2011 (Exhibit 6, page 17 and Exhibit 5, pages 25-6) are two such notification letters.

[22] A July 26, 2011 Letter from TD to the defendant, Exhibit 9, page 17, advises the defendant that as the $3,500 has been paid for the defendant to that date, the limit payable for an insured with a non-catastrophic injury and within the "Minor Injury Guidelines" had been exhausted and that no further benefit would be paid.

[23] If, as is agreed by the parties here, there is a covenant to pay by the defendant in the event that the insurer denies coverage for treatment received, the trigger to pay by the defendant would arise after the denial by the insurer. In this case, very clearly there had been denials by the insurer of the OCF 21's by May, 2011 and a very categorical statement that the $3,500 cap had been reached in July 2011.

[24] I have considered whether there was an express provision postponing payment by the defendant to some later date than the insurer's denial. There is no such language in any documents signed by or sent by the plaintiff to the defendant.

[25] I also do not see any language which would postpone the defendant's alleged "due date" to the date of some future demand. This is not expressly described or treated as a demand obligation and it is not a demand obligation by reasonable inference. It is also inconsistent with being a demand obligation that the March 2017 letter states that interest has been. The letter states: "Please note that the amount of $7,758.67 payable to our office...remains outstanding to date. Interest on the outstanding amount continues to accrue."

[26] The due date for payment of the invoiced work on the OCF 21's is, therefore, most reasonably regarded as either the same for both the insurer and the defendant (30 days after the date of the last OCF 21 being submitted) or if more time is afforded to the defendant , 30 days following the insurer's denial. The last denied OCF 21 being April, 2011, that puts the due date for both the insurer and defendant if the same no later than the end of June 2011 and if not the same, the due date for the defendant at the end of July 2011. As July 2011 is also the point at which TD states that is has exhausted the policy limit by paying out $3500 to that point, that is another reasonable basis for seeing July 2011 as the start date for the two year limitation period barring some extension under Section 5 (1) (iv).

[27] The "act or omission" for the purpose of Section 5 is, therefore, the end of July 2011 at the latest if assessing the default relative to the OCF 21's.

When did the plaintiff learn of the act or omission?

[28] The plaintiff does not argue that it did not know from the outset that the invoices were not paid.

[29] Indeed, the plaintiff presented no direct evidence on what the plaintiff intended or thought about the claim at any point prior to this lawsuit. The former employee who was involved in the claim, Ms. Gnatenko, did not testify. No other employee involved in this claim before the lawsuit testified.

[30] As I find no evidence about what the plaintiff actually knew or thought or "discovered" between 2011 and the start of the lawsuit, I do not see any evidence capable of overcoming the presumption as to knowledge of acts or omissions set by *Section 5 (2)* of the *Act*. Under that Section, a person is "presumed to have known of" the act or omission on the date on which the act or omission occurred. As set out in *Apotex Inc. v. Nordion (Canada) Inc.* 2019 ONCA 23 dislodging the presumption requires evidence that the claim was "discovered" on a date other than the act or omission and when the plaintiff "subjectively knew" it had a claim. There being no evidence of subjective intent as to some other discovery date, the act and omission date is the presumed to be the same date as the act or omission.

When did a lawsuit against the defendant become an "appropriate means" of redress?

[31] The plaintiff argues that from 2011 until November 2, 2015 it "assumed" and was operating on the "assumption" that the law firm acting for the defendant was seeking to reverse the denial of coverage by the insurer and that it was reasonable to await the exhaustion of that effort before an action against the defendant became an "appropriate" remedy under Section 5 (1) (iv).

[32] Reviewed in this section is the question of whether the evidence proves that such an assumption was made and whether, if made, it was a reasonable basis to defer the commencement of a collection action against the defendant. The conclusion I reach here is that no such assumption was proven, no such assumption was reasonable and that no such assumption explains or justifies the multi-year delay in commencing the action against the defendant. I find the two- year period for commencement of the action as commencing in or about July 2011 and that the Claim is statute barred.

[33] An issue of relevance is whether in fact **any** legal proceeding or effort to reverse the insurer's denial of the OCF 21's was undertaken by or on behalf of the defendant. The evidence of Ms. Cullingford is that the insurer's file contains no indication of any challenge being made by the law firm to the insurer's denial of the Unpaid OCF 21's.There is no record of any proceeding or mediation was held. There is evidence of Attendant Care benefits and Home Care benefits (neither being for services provided by the plaintiff) being pursued by the law firm for the defendant. There are reports in evidence of the insurer reviewing those benefit claims but there is nothing to indicate that a reversal of the insurer decision on payment of the OCF 21's was ever sought by the law firm or defendant.

[34] The evidence of Ms. Cullingford was that she was not aware of any request for mediation on behalf of defendant and she is aware of no settlement. She is not aware whether documents needed for the home care and attendant care benefits ever given to the insurer. There is no information in the insurer's records that the law firm ever disputed the insurer decision not to pay the Unpaid OCF21's. The insurer records show no change in the classification of the defendant's injuries as within the Minor Injury Guidelines. Ms. Cullingford also finds no record of a response from the law firm to the July 2011 letter saying that the $3,500 policy limit had been paid out. Looking at the insurer file and asked if the defendant ever disputed the denial of the OCF 21's, Ms. Cullingford replied: "I see no dispute in the file." An application for attendant care and home care was made but not approved.

[35] On this the plaintiff argues that it would have been reasonable to assume that if those other benefits were being pursued that a reversal of the insurer's denial on the unpaid OCF 21's would also be sought. The plaintiff notes that if all claims were being pursued they would be in one proceeding. However, there is no requirement that an insured pursue a reversal of all denials. And, it bears noting that to get a reversal of the denial of the Unpaid OCF 21's would require proof that the defendant fell outside the minor injury gap and had more serious injuries. So long as an insured is within the Minor Injury Guideline, the cap is the $3500 cap cited by the insurer in its July 2011 denial letter. There is no evidence that the defendant had more serious injuries. The Attendant Care and Home Care benefits are available to those within the Minor Injury Guidelines.

[36] The evidence from the defendant as to what the law firm was doing on his behalf is extremely unclear but it offers no support to any argument that a reversal of the denial of the OCF 21's was sought. The defendant says that he was referred to the law firm by the plaintiff. He never signed a retainer agreement and never paid any money to the firm. As he puts it, he paid not a "single penny". He recalls caregiver and home care benefits being sought on his behalf but says that he never discussed minor injury guidelines with law firm. He can't recall if any application for a denial of benefits was ever commenced. He does not know when the law firm ceased to act on his behalf. He was not made aware of any February 23, 2012 letter to the law firm.

[37] The slender reed on which the plaintiff rests its argument that the plaintiff reasonably believed a legal proceeding to seek a reversal of the denial was commenced and ongoing is a March 10, 2017 letter (Exhibit 1, page 60) which asserts that a February 23, 2012 letter was sent by the plaintiff to the defendant's law firm forwarding an invoice for the purpose of assisting the firm. The 2017 letter states that the invoice was sent to the law firm in 2012 invoice was *"with a view towards assisting the complete resolution of your [the defendant's] claim for accident benefits."*

[38] The "invoice" said to have been enclosed in 2012 is not put into evidence. The February 23, 2012 letter is not put into evidence. The author of that 2012 letter does not testify. While a purpose for sending the invoice in 2012 is asserted in the 2017 letter there is no proof that that

was in fact the purpose intended by the plaintiff in 2012. The letter is an insufficient basis for the Court inferring that the plaintiff believed at any point that a lawsuit or application had been commenced against the insurer to reverse its denial of the Unpaid OCF21's.

[39] The evidence of the plaintiff's representative Ms. Ribatachok is that the law firm never replied to the February 23, 2012 letter: "I believe we never received a response for this." Indeed, the only evidence of any communication between the plaintiff and the law firm between 2011 and November 2, 2015 is this unresponded to 2012 letter.

[40] Asked why there was no letter demanding payment sent to the defendant until March 2017 for treatments invoiced in 2011, Ms. Ribatachok replied *"we were under impression that the legal representative [of the defendant] would apply to the Licensing Appeals Tribunal"* and further that *"we were under the impression"* the legal file was *"ongoing and hadn't been settled."* She does not identify the *"we."* She does not define any basis for her view of what impressions her employer had before she became an employee. Her views are mere speculation.

[41] On cross-examination, Ms. Ribatachok testified that generally the plaintiff does not interfere with legal representation and that it is not the plaintiff's job to deal with any application but adds that here the plaintiff was not "given a certain answer" regarding any proceeding being brought. Asked why there was telephone contact in 2013 but letter in 2012, she added: *"I can't explain I was not working file at these times."*

[42] The plaintiff argues that under the *Insurance Act*, sections 279-280, only the insured and insurer are parties to an application to reverse a denial of benefits. The plaintiff also notes that any law firm would be subject to confidentiality obligations and that the plaintiff could not compel the law firm to disclose what it was doing. Accordingly, the plaintiff says, the status of any efforts to reverse the insurer's decision was unknowable to it. As the argument goes, unless expressly told that no proceeding was being brought the plaintiff says it was reasonable for it to assume a proceeding was being brought. I disagree.

[43] By the plaintiff's evidence, any application seeking to reverse the denial would have had to have been commenced within two years of the denial, therefore commenced in 2013. Just because a law firm has confidentiality obligations does not mean that it would have failed to disclose- *if asked*- that it was not pursuing a reversal of the denial by the insurer.

[44] Asked if the defendant ever provided medical documentation to assist in getting out of the minor injury guidelines, Ms. Ribatachok replies "not that I am aware of". Asked if the defendant lawyer ever disputed the minor injury categorization, her reply is that she is "not aware if the defendant lawyer disputed" that. Asked how the plaintiff would find out how an application turns out, she testified that the plaintiff would contact law firm to ask.

[45] The argument that the status of any application was unknowable to the plaintiff is at odds with the evidence of direct enquiries made by the plaintiff of the insurer after 2011.

According to the phone records, there was November 2, 2015 call by the plaintiff to the insurer asking if there was anything outstanding on the file and the plaintiff was told that the policy limit, the $3500, was reached and that there was nothing to resolve. That same advice was communicated to the plaintiff in calls logged by the insurer on May 26, 2016 and July 6, 2016. The TD notation for the May 26, 2016 call notes that the caller from the plaintiff responded to advice that the policy limit already paid out that the plaintiff "understood and will call lawyer."

[46] The evidence of Ms. Culingford on cross-examination also included reference to a fax having been sent by plaintiff to TD Insurance on November 26, 2014 asking if can resolve outstanding balance and of the response being that the policy limit of $3,500 had been reached. Ms. Cullingford testified to a contact on February 18, 2015 as well.

[47] There is no question but that Section 5 (1) (a) (iv) of the Act, relied on by the plaintiff, reflects a policy concern that unnecessary litigation be discouraged and that plaintiffs be permitted the time necessary to await alternate recourse or repair proceedings for any given claim. However, as the Court of Appeal noted *in Presidential MSH Corporation v. Marr, Foster & Co. LLP et al* 2017 ONCA 325, in applying the appropriateness test the Court must avoid "undesirable uncertainty." Hope may spring eternal but the limitation period is not so elastic. Some concrete and alternate remedy or recourse proceeding must be in process and be proven to have been reasonably relied on before a reasonable case for extending the two- year period can be justified. The plaintiff has not proven that it assumed ongoing proceedings. The plaintiff has not proven that any such assumption would have been reasonable. Its assertion that it relied on silence from the insurer and defendant and law firm on the issue is not reasonable. It was never told an reversal of the insurance decision was ever sought and failed to research the point by even minimal timely enquiries.

[48] For the reasons set out above, I find in favour of the defendant and dismiss the claim.

[49] If the parties are unable to agree on costs, they may make submissions as to costs to the Small Claims Court Office in accordance with the following timetable: defendant to serve and file by August 22,2022; and plaintiff to serve and file by August 31,2022. If the parties representatives need an extension in the deadline because of summer holiday absences, they can contact the Court in advance of the first of the two deadlines to request same.

Date of Judgment: August 3, 2022

A. McNeely, D.J.-S.C.J.