CITATION: Muddapati v. Primmum Insurance Company, 2026 ONSC 1878
DIVISIONAL COURT FILE NO.: 812/25
DATE: 20260331

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

S.T. Bale, O'Brien and Brownstone JJ.

BETWEEN:	
AKANKSHA MUDDAPATI Appellant	*Arvin Gupta* and *Emma Painchaud*, Counsel for the Appellant
– and –	
PRIMMUM INSURANCE COMPANY Respondent	*Matthew Samuels*, Counsel for the Respondent
	HEARD on March 23, 2026, at Toronto

O'BRIEN J.

REASONS FOR DECISION

Overview

[1] The appellant Ms. Muddapati appeals from a preliminary issue decision of the Licence Appeal Tribunal dated September 4, 2025, in which the Tribunal found that she was barred from proceeding with her application by the doctrine of *res judicata*.

[2] The appellant was involved in an automobile accident on May 2, 2020. She sought and was denied statutory accident benefits from her insurer, the respondent. She then applied to the Tribunal for a determination of her entitlement to benefits. In an initial decision dated September 26, 2024, the Tribunal denied coverage for treatment costs beyond the *Minor Injury Guideline* (MIG). Subsection 18(1) of O. Reg. 34/10: Statutory Accident Benefits Schedule – Effective September 1, 2010 (the *SABS*) limits benefits for an insured person who sustains an impairment that is "predominantly a minor injury" to $3,500.

[3] The appellant subsequently sought benefits for additional treatment plans, which the respondent denied. The appellant then applied to the tribunal for a resolution of this second dispute. On a preliminary issues hearing held with respect to the dispute, the respondent argued that any further consideration of the question of whether the appellant's injuries fell within the MIG was barred by *res judicata*.

[4] The Tribunal agreed. In its September 4, 2025 decision, the Tribunal concluded *res judicata* applied because the Tribunal's initial decision had decided the same issue on a final basis between the same parties. The appellant submitted *res judicata* should be waived, relying on two pieces of what she considered to be new evidence: (1) the insurance adjuster's log notes, which she said reflected that the respondent had determined her injuries did not fall within the MIG; and (2) a psychiatric report obtained from an insurer's examination, which diagnosed the appellant with a chronic somatic symptom disorder.

[5] The adjudicator was not persuaded *res judicata* should be waived. She reasoned that the appellant could have requested the adjuster's log notes in time for the previous hearing. In any event, the notes were not medical evidence that would conclusively impeach the original finding that the appellant had a non-MIG injury. The adjudicator also found the new medical report did not constitute evidence that was previously unavailable and that would question the validity of the original result.

[6] The adjudicator also dismissed the appellant's submission that the respondent had contravened s. 38(9) of the *SABS*, and that this provided a further basis to waive *res judicata*. Subsection 38(9) requires an insurer to notify the insured person if the insurer believes the MIG applies to the insured person's impairment. The adjudicator noted the evidence that the respondent had notified the appellant that her injuries fell within the MIG on September 27, 2021, before the treatment plans in dispute. Aside from the notice issue, she stated it was the appellant's evidentiary burden to establish that her injuries were outside the MIG.

[7] The test for *res judicata* is set out in *Danyluk v. Ainsworth Technologies Inc.*, 2001 SCC 44, [2001] 2 SCR 460, at para 25. It can be applied where: (1) the same question has been decided; (2) the judicial decision that is said to create the estoppel was final; and 3) the parties to the judicial decision or their privies were the same persons or parties to the proceedings in which the estoppel is raised or their privies. An administrative tribunal also has a discretion to refuse to apply the doctrine.

[8] The parties agree that the Tribunal stated the correct test, but the appellant argues it misapplied the test in the circumstance of the case. The appellant's primary argument in this court is that the Tribunal erred in its interpretation of s. 38(9). She also submits the Tribunal erred in failing to waive the application of *res judicata* because of the new evidence.

[9] For the following reasons, I would dismiss the appeal.

Standard of Review

[10] Under s. 11(6) of the *Licence Appeal Tribunal Act, 1999*, S.O. 1999, c. 12 Sched. G., an appeal from the Tribunal is limited to questions of law. The standard of review is correctness: *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65, at para. 37.

Did the Tribunal err in finding *res judicata* applied despite the requirements of s. 38(9)?

[11] The appellant submits s. 38(9) of the *SABS* required the insurer to provide her with specific notice, in the letters sent in response to the treatment plans, that it was not paying for the benefits claimed because her impairment fell within the MIG. She relies on s. 38(11) of the *SABS* to say that, in the absence of a compliant notice, the respondent could not take the position she was in the MIG and was required to pay for the benefits claimed until it provided a compliant notice.

[12] I disagree with the appellant's position. There is no question that s. 38(9) requires the insurer to provide the insured with notice of its belief that the person's impairment falls within the MIG. The insurer's initial notice obligation in response to a treatment plan is set out in s. 38(8). That provision requires the insurer, within 10 days of receiving a treatment plan, to give notice of which benefits it agrees to pay for, which it does not, and the reasons why it considers the denied benefits not to be reasonable and necessary. Subsection 38(9) then deals with notice that the insurer believes the insured falls within the MIG. It states:

> 38(9) If the insurer believes that the Minor Injury Guideline applies to the insured person's impairment, the notice under subsection (8) must so advise the insured person.

[13] Subsection 38(11) sets out the consequences if the insurer fails to give the notice required by subsection (8). It states:

> (11) If the insurer fails to give a notice in accordance with subsection (8) in connection with a treatment and assessment plan, the following rules apply:
>
> 1. The insurer is prohibited from taking the position that the insured person has an impairment to which the Minor Injury Guideline applies.
>
> 2. The insurer shall pay for all goods, services, assessments and examinations described in the treatment and assessment plan that relate to the period starting on the 11th business day after the day the insurer received the application and ending on the day the insurer gives a notice described in subsection (8).

[14] The appellant relies on subsections (9) and (11) to say the respondent did not give notice that it believed the appellant was within the MIG and, therefore, it was prohibited from taking that position.

[15] The problem with the appellant's position in the circumstances of this case is there is no dispute that the respondent did give the appellant notice of its view that the appellant's impairment fell within the MIG, well before the treatment plans in dispute. In addition, it pursued this position

when the appellant first applied to the Tribunal. As set out above, the Tribunal agreed that the appellant's injuries fell within the MIG.

[16] The appellant relies on *Zheng v. Aviva Insurance Co. of Canada*, 2018 ONSC 5707 to say this initial notice was not sufficient. She argues the insurer was required to give notice about the MIG each time it responded to a treatment plan. But *Zheng* does not deal with a situation where the insurer previously complied with s. 38(9) and maintained that position before the Tribunal. The appellant has not provided any authority for the proposition that the insurer must provide repeated notices of its position under s. 38(9) when that position has not changed.

[17] The purpose of the MIG, as set out in *Zheng*, is to establish a treatment framework for an insured who has sustained a minor injury. It permits an insured immediate access to medical treatment without insurer approval and is intended to provide speedy access to rehabilitation for persons with minor injuries: *Zheng*, at para. 12. Section 38 of the SABS, by contrast, establishes a procedure to apply for benefits other than those payable under the MIG.

[18] In the current case, the appellant had already received benefits to the MIG limit by the time she submitted the treatment plans in dispute. There was no issue with obtaining immediate access to treatment. The insurer therefore obtained a medical report following an insurer examination to determine whether anything had changed that would mean the non-MIG provisions of the SABS would apply. It concluded they did not. The appellant has not persuaded me that s. 38 should be read as requiring an additional notice from the insurer in a situation where the MIG benefits have been exhausted and the insurer has not changed its position that the insured's injuries fall within the MIG.

[19] I do not see any basis to interfere with the adjudicator's rejection of the submission that s. 38(9) provided a reason to waive *res judicata* in this case.

Did the Tribunal err in failing to waive *res judicata* because of the proposed fresh evidence?

[20] The appellant also submits that the adjudicator erred in failing to waive *res judicata* because of the adjuster's log notes and the new medical report.

[21] With respect to the adjuster's log notes, the appellant's argument mostly depends on her s. 38(9) submission. She says the log notes provide evidence that the respondent did not believe her injuries were within the MIG. In her submission, this shows that notice under s. 38(9) was required.

[22] There is no error in the adjudicator's conclusions that (1) the adjuster's log notes could have been obtained in time for the original hearing; and (2) would not conclusively impeach the results from the original hearing. The adjudicator found that the respondent was initially advised the appellant had a fractured leg. On review of medical records, it was later discovered there was no fracture. In the meantime, the respondent had approved funding for psychological treatment beyond the MIG limits. This explains why the adjuster's log notes reflect the appellant not being within the MIG limit, even though the respondent gave notice that she was and pursued that position at the original hearing. I would not interfere with the Tribunal's conclusion that the log notes were not a basis to waive *res judicata*.

[23] I also would not interfere with the Tribunal's rejection of the medical report as a basis for waiving *res judicata*. The medical examiner reached a new diagnosis, but, as the Tribunal found, the doctor did not consider new information that was previously unavailable. As G.P. Smith J. stated in *Penny v. Royal & Sun Alliance Insurance Co.*, [2006] O.J. No. 2858 (SCJ), at para. 78, to allow a party to submit better medical evidence after an unsatisfactory initial result would "make a mockery of the principle of the finality of litigation." Although in that case, the plaintiff had obtained the new report, rather than submitting a report following an insurer's examination, the point is that the appellant could have obtained her own medical report before the initial hearing. In any event, it is not clear the new report would have assisted the appellant, since it did not address the MIG issue and the doctor concluded the benefits sought were not reasonable and necessary.

Disposition

[24] For the reasons given, I would dismiss the appeal with costs payable by the appellant to the respondent in the agreed-upon amount of $7,500.

"O'Brien J."

"I agree. S.T. Bale J"

"I agree. Brownstone J"

Released: March 31, 2026

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