SECTION 44 ASSESSMENTS:

HOW THE COURTS AND FSCO ASSESS THE INSURER'S POSITION

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1. AREN'T THEY ALWAYS REASONABLE AND NECESSARY?

Insurer examination assessments are one of the most useful tools that an insurer may utilize in terms of adjusting and assessing the file. There are many other means at the disposal of the insurer: examination under oath (pursuant to section 33 of the *Schedule*), request for productions and information, a statutory declaration (pursuant to section 33 *Schedule*), and conducting surveillance. However, the insurer examination addresses specifically those benefits that are claimed, by way of in person (or paper review) assessment of the Applicant, and provides the ability to assess their physical, psychological, and cognitive complaints, as well as their actual function.

There is the belief that section 44 assessments are requested, and then they must automatically be complied with. Insurer examinations are not an automatic right of the insurer. When an Applicant refuses to comply, this may result in a preliminary issue being heard, to determine if the request for an assessment is reasonable and necessary, and to also perhaps assess if the notice requirements, set out in section 44, were complied with.

Section 44 reads as follows:

> 44. (1) For the purposes of assisting an insurer to determine if an insured person is or continues to be entitled to a benefit under this Regulation for which an application is made, **but not more often than is reasonably necessary**, an insurer may require an insured person to be examined under this section by one or more persons chosen by the insurer who are regulated health professionals or who have expertise in vocational rehabilitation. O. Reg. 34/10, s. 44 (1).

The wording under section 42 of the previous legislation read as follows:

> **42.** (1) For the purposes of assisting an insurer determine if an insured person is or continues to be entitled to a benefit under this Regulation for which an application is made, an insurer may, **as often as is reasonably necessary**, require an insured person to be examined under this section by one or more persons chosen by the insurer who are members of a health profession or are social workers or who have expertise in vocational rehabilitation. O. Reg. 546/05, s. 21.

While there are slight differences in wording, notably "not more often than is reasonably necessary" and "as often as is reasonably necessary" the case law has interpreted the two sections to read as similar enough to have the same applicability.

There is no power for an Arbitrator to order an insured person to attend an insurer examination, however the Arbitrator has the power, pursuant to section 23(1) of the *Statutory Power Procedures Act*, to control the process to ensure a fair hearing, which may, and often does, result

in an order to stay a proceeding pending attendance at an IE. It is at the discretion of the Arbitrator.

What considerations must be contemplated prior to a determination of whether the request by the insurer is "reasonable and necessary"? An evolution of specific criteria to implement has grown.

In ***F.S. and Belair*** (OIC P96-00039, June 11, 1996) Director's Delegate Naylor determined that an IE may be required after a termination of benefits in a "continuing and evolving claim for ongoing benefits", especially "where the basis of the claim substantially changed after mediation commenced".[1]

Director's Delegate Naylor also clarified that considering the request for an insurer examination requires a balancing of interests of the parties [2].

In ***State Farm and Ramalingam*** (P05-00026, August 13, 2007), Director's Delegate Makepeace set out factors to be considered when determining if the request for an insurer examination was reasonable and necessary. These had been developed in previous decisions and evolved to those articulated by Director's Delegate Makepeace:[3]

- Timing of the request for attendance at an insurer examination
    - Was the request right before a hearing?
    - Has the insurer been requesting this attendance for some time?
    - Will attendance at the insurer examination create delay?
- Did the claimant disclose relevant materials as soon as reasonably possible in accordance with Dispute Resolution Practice Code and the *Schedule?*
- What other information is available to the insurer?
- If the information provided by the claimant since the last insurer examination suggests a new diagnosis, a change in condition, or a new direction of medical investigation.
    - In *Ramalingam*, Director's Delegate Makepeace found that an arbitrator must consider all relevant circumstances, and not just a change in a test to determine if the insurer examination request is reasonable

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[1] *F.S. and Belair* (OIC P96-00039, June 11, 1996) pp. 8 and 13

[2] Ibid, pp. 7-8

[3] *State Farm and Ramalingam* (P05-00026, August 13, 2007) p. 12

- Is there a reasonable nexus between the requested IE and the insured person's injuries?
    - Are the complaints physical, and is the insurer requesting a psychological examination?
- Whether the insurer accepts the claim and continues to pay benefits
- There must be a balance between the insured's right to privacy, and the insurer's ongoing right and obligation to assess the claim

Contemporaneously, in ***Al-Shimasawi and Wawanesa*** (FSCO A05-002737, May 11, 2007) Arbitrator Feldman enunciated similar criteria as set out in *Ramalingam*:

a. The onus is on the insurer to establish that the insurer examination is reasonable

b. Is the insurer examination required to assess the validity of the claim, or respond to new claim, rather than for purposes of "trial brinkmanship", or an attempt to bolster the insurer's position at a hearing?

c. In assessing the reasonableness, FSCO will consider:

    i. Timing

        (1) The insurer has an ongoing responsibility to assess the insured person and any information received

        (2) The fact that the insurer may have already denied a benefit or that the dispute process has commenced does not automatically preclude the insurer from requesting reasonable assessments

        (3) A request for an insurer examination can be made even if there is a delay from the time the insurer knew or ought to have known about the impairment

        (4) The closer the request comes to the date for commencement of the hearing, the greater the scrutiny as there will be greater likelihood of prejudice to the Applicant

        (5) There is no presumptive right to an insurer's examination at 104 weeks where an insurer has already terminated benefits on the basis the Applicant has failed to meet pre 104 week income replacement benefit test

    ii. Prejudice to both sides

        (1) It is recognized that IE's are "inherently intrusive"

(2) There must be an investigation into whether the insurer is using excessive insurer examinations to harass or intimidate the Applicant

(3) Is there evidence that the assessment will adversely affect the health of the claimant?

(4) Will it delay the hearing?

(5) There may be prejudice to the insurer's ability to assess the claim adequately if the insurer is not able to have the requested assessment conducted

iii. Number and nature of previous insurer examinations

iv. Nature of the examination(s) being requested

v. Are there any new issues being raised in the Applicant's claim?

vi. Is there a reasonable nexus between the examination requested and the Applicant's injuries

In ***Carpenter and Farmers*** (FSCO A07-001980, July 31, 2008), Arbitrator Feldman added a further consideration: that "a stay of proceedings is an exceptional remedy", not set out in the *Schedule* or the *Dispute Resolution Practice Code,* that arises out of section 23of the *SPPA* as noted above. Thus, where an arbitrator evaluates the reasonableness of the request for an insurer examination, they then have the authority, pursuant to their jurisdiction, to institute a remedy for a stay pending attendance, in order to ensure procedural fairness.

In ***Certas v. Gonsalves***, 2011 ONSC 3986, a Judicial Review of the appeal decision at FSCO, the court set out further concepts to consider:

a. Fairness is fundamental to the process

b. The insurer must be able to make full answer and defence (there can be no trial by ambush)

At the arbitration level, Arbitrator Rogers had found that an insurer had a *prima facie* right to an examination where there had been a change in circumstance.

In ***Albanese and State Farm*** (FSCO P11-00023, December 20, 2011) Director's Delegate Blackman, while acknowledging the findings of the Divisional Court, found that while this third principle enunciated by Arbitrator Rogers had not been adopted, that the reasons for supporting it were consistent with the decision in *Gonsalves.* He noted that this change must still be balanced with other considerations.

Clearly, the process is one that is fact specific, and requires a detailed analysis of the criteria and must balance the interests of all parties.

2. PROPER/IMPROPER NOTICE AND REMEDIES

What happens when a notice by the insurer does not comply with the requirements as set out in section 44?

> 44(5)If the insurer requires an examination under this section, the insurer shall arrange for the examination at its expense and shall give the insured person a notice setting out,
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> (a) the medical and any other reasons for the examination;
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> (b) whether the attendance of the insured person is required at the examination;
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> (c) the name of the person or persons who will conduct the examination, any regulated health profession to which they belong and their titles and designations indicating their specialization, if any, in their professions; and
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> (d) if the attendance of the insured person is required at the examination, the day, time and location of the examination and, if the examination will require more than one day, the same information for the subsequent days. O. Reg. 34/10, s. 44 (5).

This section must be read in conjunction with section 36, 38, 42 and 43 with respect to notice given regarding the determination of benefits.

Medical and Other Reasons

In the previous SABS, the requirement was only that the insurer provide the "reasons for the assessment". In the current Regulation, there is a requirement that the insurer provide the "medical and other reasons" that the assessment is being requested.

What are medical and other reasons? The only case to date that addresses this issue in any great detail is ***Augustin and Unifund*** (FSCO A12-000452). The term "medical reasons" is not defined in the *Schedule.* None of the Guidelines issued by FSCO set out what a "medical reason" is. In *Augustin,* Arbitrator Sapin gives some hints as to what might constitute a "medical reason". She states that in the case of a denial of medical benefits, the insurer should indicate that the treatment and assessment plan has been reviewed, as well as any submitted medical documentation, and that those documents were compared to the MIG for example, and

> *"determined either that there is insufficient compelling evidence (of pre-existing injuries or conditions, for example) or insufficient medical documentation to persuade it that the accident injuries fall outside of the MIG and therefore, the insurer believes the MIG applies and the treatment*

> *claimed is not reasonable or necessary (because the treatment does not conform to the MIG treatment protocols, for example)"*[4]

The requirement to have medical and other reasons disclosed to the insured ensures, according to Arbitrator Sapin, that an arbitrary refusal of benefits is minimized.

Arbitrator Sapin also opines that the need to provide medical reasons within the Notice "eliminates the expense of an automatic initial IE".[5] However the right to a discretionary IE is not maintained if the insured person claims that their injuries fall outside of the MIG and the insurer assesses them for same. Thus, Sapin asserts that the new SABS make insurers accountable for any determinations that limits or denies initial treatment. [6]

Augustin provides little guidance with what constitutes a medical reason. Arbitrator Sapin claims this is not necessarily an opinion based on a health practitioner, as was claimed by the Applicant. She also states that insurers are not required to hire in house medical staff to review incoming claims. "A medical reason is not the same as a medical opinion".[7] She also goes on to state that the need for a medical opinion, as sought by the initial IE, is not "sufficient to satisfy the definition of medical reason". [8]

It appears that if Unifund had indicated that it did not have enough "medical information" to make a determination that the MIG applied, as well as that Augustin's treating practitioner had not provided any compelling reasons as to why the MIG did not apply, that Arbitrator Sapin would have found those sufficient "medical reasons" to satisfy the requirement set out in section 44(5)(a).

In an earlier decision, *TD and Anthonypillai,* Director's Delegate Evans confirmed the decision given by the hearing arbitrator, which had precluded TD from conducting an insurer examination. Director's Delegate Evans found that TD had failed to give any medical reasons for the examinations, nor did the Notice provide the information set out in section 44(5)(c), and that further Notices did not remedy the deficiencies.[9] Director's Delegate Evans did not however speak to what "medical reasons" might mean or include.

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[4] *Augustin and Unifund* (FSCO A12-000452, November 13, 2013), p. 9

[5] Ibid.

[6] Ibid.

[7] Ibid, p. 10

[8] Ibid.

[9] *TD and Anthonypillai,* FSCO P11-00005, March 5, 2012, p. 10.

Medical reasons however do not encompass an insurer advising that they require a "second opinion". [10]

Consequences of Failure to Give Sufficient Notice

It is abundantly clear that the decision in *Smith v. Co-Operators*[11] confirmed that the Statutory Accident Benefit Schedule is consumer protection legislation. The insurer is considered a sophisticated party that must ensure that its dealings with their insureds are clear, unequivocal, and fair.

Further, in *Smith*, the Court confirmed that a Notice may be invalid, even if approved by the Superintendent of Insurance, if the insurer does not take steps to ensure that all of the required and relevant information to be communicated to the insured person is not included.

In *Ives and Wawanesa*, the Insurer did not give the insured person notice required by then subsection 42(4), as the information was discussed, and attendance at an IE was agreed upon, at a prehearing. Arbitrator Renehan confirmed that parties cannot "waive" compliance with this section, and furthermore, if no Notice was given, he could not determine whether the examination was "reasonably required". [12]

Where an insurer indicates the wrong specialty of an assessing practitioner on a Notice, the Notice may be found to be deficient.[13]

Noting "income replacement benefits" on the heading of "Types of Examination" on the Notice is not sufficient to comply with the Regulation. An "income replacement benefit" is a benefit, and not a type of examination to be conducted. Arbitrator Murray clarified that a type of examination may include a functional ability evaluation, an in home assessment, or an orthopaedic evaluation, among others.[14] It is not enough for the insurer to list that the practitioner is a neurologist, but they must state that the type of examination is a neurological assessment. As Arbitrator Murray notes, "in many instances the type of examination that will be conducted can be inferred from an individual's 'specialization', but this is not always the case". [15]

In the *Faiz* matter, Arbitrator Murray found that if the notice was deficient, then the insurer cannot be entitled to an Order that the proposed IE was reasonable and necessary.

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[10] *Quinones and Unifund*, FSCO A12-000866, August 2, 2013, p. 6

[11] *Smith v. Co-Operators General Insurance Company* 2002 SCC 30

[12] *Ives and Wawanesa*, FSCO A05-002144, June 22, 2006, at p. 3

[13] *Faiz and Wawanesa*, FSCO A06-001588, August 31, 2007, p. 8

[14] Ibid.

[15] Ibid, p. 9

Arbitrator Mervin however found that where an insurer did not specifically indicate that they intention was to address post 104 week IRB's, but noted that the assessment was to address "Income Replacement Benefits", this was sufficient and should not bar the insurer from conducting the proposed assessment. [16]

Simply stating that the assessment is to be conducted by an "OT" is also not sufficient. An "unsophisticated person may not know what an OT is". The Profession or Designation portion of the Notice should clearly set out the regulated health profession to which the provider belongs. [17]

An insurer cannot claim that information missing from a Notice is a "technical deficiency", as the information is specifically set out in section 44(5) and neither party is entitled to waive the requirement. [18]

Correction of Deficient Notice

In *Faiz,* Arbitrator Murray noted that the insurer did not correct its incorrect classification of a practitioner as a neurologist rather than an ophthalmologist. As such, the notice was deficient and she did not appear to accept a later letter that clarified the mistake.

In *Shin and Co-Operators,* Arbitrator Murray asserted that while the insurer attempted to rectify an incorrect Notice by a later letter, arbitrators had generally "rejected the piecemeal approach" and that to require an insured to "piece together information from scattered documents" was not in the spirit of *Smith.*[19]. As a result, she found that the request for an insurer examination was not reasonable and necessary as it had been made improperly.

3. SECTION 55 DEFENCES

Section 55 of the *Schedule* sets out the following:

> 55. An insured person shall not commence a mediation proceeding under section 280 of the Act if any of the following circumstances exist:
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> 1. The insured person has not notified the insurer of the circumstances giving rise to a claim for a benefit or has not submitted an application for the benefit within the times prescribed by this Regulation.

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[16] *Yan and State Farm Mutual Automobile Insurance Company,* FSCO A12-004991, August 28, 2014, p. 7.

[17] Supra, note 10, at p. 7

[18] *Phillipaiya and TD Home,* FSCO A12-001040, September 6, 2013, p. 7

[19] *Shin and Co-Operators,* FSCO A06-00232, May 25, 2009, p. 6; further see *Yee and Lambton Mutual Insurance Co.* FSCO A02-001550, September 16, 2003)

2. **The insurer has provided the insured person with notice in accordance with this Regulation that it requires an examination under section 44, but the insured person has not complied with that section.**

3. The issue in dispute relates to the insurer's denial of liability to pay an amount under an invoice on the grounds that,

   i. the insurer requested information from a provider under subsection 46.2 (1), and

   ii. the insurer is unable, acting reasonably, to determine its liability for the amount payable under the invoice because the provider has not complied with the request in whole or in part

The earlier SABS did not prevent an insured person from proceeding to mediation/arbitration on the basis of non-compliance with section 42. The previous section 50 only prohibited an insured person from commencing a mediation proceeding of they had not undergone a designated assessment under then section 43. Arbitrator Murray, in *Garminder and Co-Operators,* confirmed that section 50 of the previous legislation was only applicable to DACS, and not to insurer examinations. [20]

Insured's have not been barred from proceeding to mediation on this basis as they have been entitled to raise the issue of possible deficient notices, or to dispute the reasonableness of the insurer's request. However, it is prudent for the insurer to raise a preliminary issue at mediation, to then raise the issue at a prehearing, and to seek a preliminary issue hearing regarding same. This would require an analysis as noted above, to determine if the request for the assessment was reasonable and necessary.

In *Augustin,* Arbitrator Sapin denied the insurer's right to rely upon section 55 on the basis that the Notice was deficient. [21] She confirmed that as the section 55 remedy is a serious consequence to the insured person, as they would be barred from proceeding with disputing that benefit, that the requirements set out in section 44(5) must be strictly construed. [22]

It seems, according to *Augustin,* that only after the Notice is deemed compliant, and the IE is deemed to be reasonable and necessary, and the insured person has not attended at the examination, that the section 55 defence may be utilized. By referring to section 44 in section 55, the legislature attempted to restrict the use of IE's to "not more often than is reasonably necessary". [23]

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[20] *Garminder and Co-Operators,* FSCO A12-006193, October 22, 2013, p. 13

[21] Supra Note 4, at p. 11

[22] Ibid, at p. 12

[23] Ibid, at p. 14

In *Quinones*, Arbitrator Murray also refused to permit the insurer to claim a section 55 defence on this basis. [24]

Section 55 provides relief to an insurer where an insured person has "commenced" a mediation. However, if the mediation proceeding has already been commenced, this section cannot be utilized to prohibit the insured person from "continuing" a mediation. The insurer's request for an examination must be received before an insured person starts their mediation. [25]

Where an insured person cannot show non compliance with section 44, and provides no acceptable reason for non attendance at an insurer examination, an insurer may be granted the remedy set out in section 55. [26]

Thus, the determination of whether section 55 will apply, as section 44(5), will be left to the trier of fact, to assess upon review of all the relevant information and documentation. If an insurer relies upon a section 55 defence, the insurer must ensure that it has been compliant with section 44(5), and that the examination that has been requested is "reasonable and necessary" in light of all of the jurisprudence.

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[24] Supra, note 10, at p. 8

[25] *Kozin and Certas*, FSCO A12-005148, November 21, 2013, p. 3

[26] *Maude and State Farm*, FSCO A12-003997, September 30, 2014, at p. 7