Accident Benefit Reporter

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THE "MEDICAL AND OTHER REASONS" REQUIRED TO JUSTIFY AN INSURER EXAMINATION

The purpose of this article is to provide a brief "refresher" on the scope of the "medical and other reasons" that must be provided by an insurer to its insured when an insurer examination ("IE") is being requested.

Save for the exceptionally lucky, most people who have been injured as a result of a motor vehicle accident and who have claimed accident benefits from an insurance company have at some point received a letter from the insurer requesting that they attend an IE. The letter usually reads along the lines of:

> *We are in receipt of the Assessment and Treatment Plan (OCF-18) dated May 1, 2017 authored by John Doe for physiotherapy treatment in the amount of $1,800.00.*
>
> *We are unable to approve this plan as we have insufficient medical information in the file to support the need for ongoing physical treatment.*

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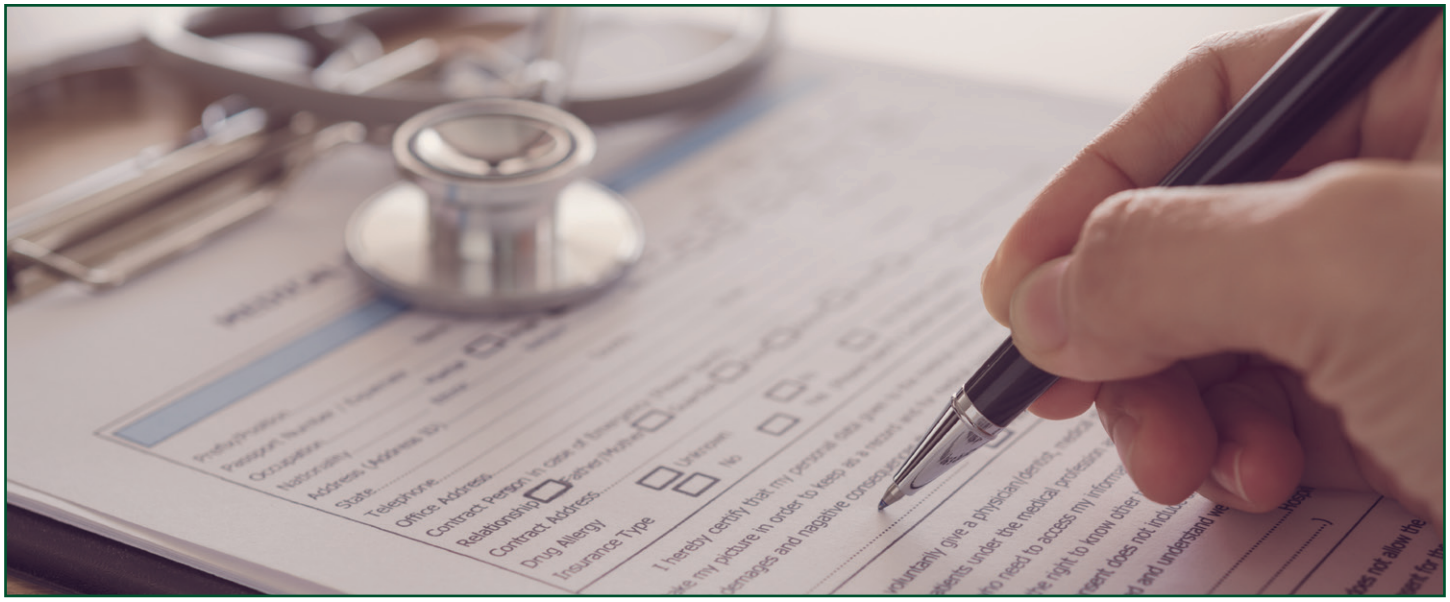

Please be advised that we are referring you for an insurer examination in accordance with section 44 of the Statutory Accident Benefits Schedule.

A Notice of Examination is attached.

When an insurer wishes to send its insured to an IE there are certain notice requirements that must be satisfied. Those requirements are set out in section 44(5) of the *Statutory Accident Benefits Schedule*[1] as follows:

a. the medical and any other reasons for the examination;

b. whether the attendance of the insured person is required at the examination;

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

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.

Where an insurer's notice fails to satisfy the requirements of section 44(5), the insured *may* be justified in refusing to attend the requested IE. That refusal, however, is not without risk. The refusal *could* later be used against the insured as a means of precluding the insured from being able to dispute the denial of the benefit at the Licence Appeal Tribunal ("LAT"). Specifically, section 55(1) of the *SABS* provides:

Subject to subjection (2), an insured person shall not apply to the Licence Appeal Tribunal under subsection 280(2) of the Act if any of the following circumstances exist:

(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.

It seems that as of late, subsection (a), the requirement for the insurer to provide "medical and other reasons" for the IE has become a "hot button issue". Insureds have been dissatisfied with the reasons provided, have refused to attend the IEs, and have been faced with preliminary challenges at the LAT hearings as to whether they are barred from proceeding due to the refusal to attend. Recent decisions at both the Financial Services Commission of Ontario and the LAT have sought to better define the scope of the "medical and other reasons" that are to be provided by insurers.

Below is a list of principles and excerpts arising from a number of decisions released since 2016. While this list is not meant to be exhaustive, it should provide insureds, insurers, and their respective lawyers with a better understanding as to the rationale for the requirement to provide "medical and other reasons" and what may be required to satisfy that requirement.

- Requiring medical reasons makes insurers accountable for their decisions and prevents them from acting arbitrarily. Insured persons must provide valid, factual medical information from health practitioners to support their claims. Likewise, insurers must provide reasons encompassing more than a desire to determine ongoing entitlement. There must be something in the medical records that leads to questions and warrants investigation.[2]

- The medical and other reasons are the reasons that are unique to each case and that justify the insurer's request for further investigation.[3]

- The onus is on the insurer to provide the medical reason(s) for the IE; and "common sense" will not suffice.[4]

- A medical reason must be provided. The statute does not state "medical and/or any other reason."[5]

- Insurers must explicitly and unambiguously advise insureds of the medical and other reasons in straightforward and clear language, directed towards an unsophisticated person.[6]

- The mere mention of the receipt of specific medical reports does not, in and of itself, meet the "medical reasons" test, let alone does it determine whether the IE may be reasonable and necessary.[7]

- When the issue is whether or not the insured falls within the Minor Injury Guideline ("MIG"), the notice must at least include statements that the adjuster: 1) has reviewed the MIG; 2) has reviewed the treating health practitioner's medical opinion; and 3) has concluded that the health practitioner has not provided compelling evidence that the person's injuries are outside the MIG, or that the treatment claimed is not reasonable or necessary.[8]

In summary, insurers must be held accountable for their requests for IEs. These requests are not supposed to be prompted by the mere passage of time on a given file or for some other arbitrary reason. Rather, there must be specific medical reasons that result in uncertainty, a change in condition, or otherwise that sufficiently justify the need for the IE. Insureds are well within their right to seek further clarification from insurers as to the medical reasons for the IE or, potentially, to refuse to attend the IE when no medical reasons have been provided (though the latter route does bear risk). ■■■

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[1] *Statutory Accident Benefits Schedule – Effective September 1, 2010*, O. Reg. 34/10 [SABS].
[2] *J.W. v. The Co-Operators General Insurance Company*, LAT 16-000248/AABS (15 November 2016) at para. 12.
[3] *Ibid. at para. 23*
[4] *M.B. v. RBC General Insurance Company*, LAT 16-002963/AABS (5 April 2017) at para. 16.
[5] *Ibid.* at para. 20.
[6] *Ni v. TD Home and Auto Insurance Company*, FSCO A13-013501 (27 April 2017) at 6.
[7] *Ward v. State Farm*, FSCO A14-010161 (15 January 2016) at 6.
[8] *Clancy v. Aviva Canada Inc.*, FSCO A15-001101 (19 December 2016) at 11-12.

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UPCOMING EVENTS 2017

EVENTS
2017

June 23 BIST's Birdies for Brain Injury Golf Tournament – Lionhead Golf and Country Club, Brampton. For more information click here.

September 28 Back to School Conference: ABI Across the Ages co-hosted by PIA Law and Toronto ABI Network – The Carlu, Toronto. For early bird registration click here.

October 1 BIST 5K Run, Walk and Roll in Support of Acquired Brain Injury – Wilket Creek Park, North York.

Nov 1-3 Acquired Brain Injury Provincial Conference hosted by Ontario Brain Injury Association – Sheraton on the Falls Hotel, Niagara Falls. For more info, click here.

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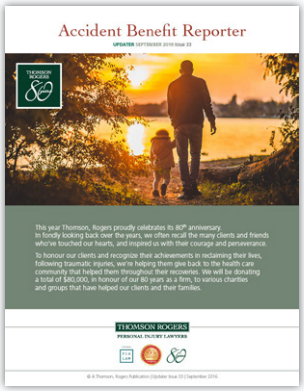

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