Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A12-000452

BETWEEN:

KADIAN AUGUSTIN

Applicant

and

UNIFUND ASSURANCE COMPANY

Insurer

DECISION ON A PRELIMINARY ISSUE

Before: Susan Sapin

Heard: January 29, 2013, at the offices of the Financial Services Commission of Ontario in Toronto.Written submissions were received on January 23, 2013.

Appearances: Alexander Mazin for Ms. Augustin
Jacqueline Bunt for Unifund Assurance Company

Issues:

The Applicant, Kadian Augustin, was injured in a motor vehicle accident on July 2, 2011. She applied under the *Schedule*[1] for medical and attendant care benefits and claims a weekly non-earner benefit (NEB) from Unifund Assurance Company ("Unifund"). Unifund refused to pay for medical benefits on the basis that Ms. Augustin failed to attend insurer's examinations (IEs) to determine whether her accident injuries fell within the Minor Injury Guideline (MIG),[2] and now argues her failure to attend the IEs precludes her from mediating its refusal. Unifund has refused to pay an NEB because it maintains Ms. Augustin did not apply for it.

[1] *The Statutory Accident Benefits Schedule - Effective September 1, 2010, Ontario Regulation 34/10, as amended.*

[2] This *Guideline* came into effect under the most recently amended *Schedule* and applies to all accidents after September 1, 2010. In this case, the applicable MIG is *Superintendent's Guideline No. O2/10 June 2010*, the guideline that preceded the one currently in force, as Ms. Augustin's claim documents were delivered before November 1, 2011.

The parties were unable to resolve their disputes through mediation, and Ms. Augustin applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as amended.

The preliminary issues arising from this dispute are properly framed as follows:

Preliminary issues:

1. Is Ms. Augustin precluded from commencing a mediation proceeding regarding Unifund's refusal to pay her claims for treatment by s. 55.2 of the *Schedule* because she did not attend an IE for which Unifund sent her a notice under s. 44?

2. Is Ms. Augustin precluded from pursuing or mediating a claim for an NEB by s. 55.1 of the *Schedule* on the basis that she did not submit an application for the benefit?

Result:

1. Ms. Augustin is not precluded from commencing a mediation proceeding by s. 55.2 of the *Schedule.*

2. Ms. Augustin is not precluded from pursuing or mediating her claim for an NEB.

EVIDENCE AND ANALYSIS:

Is Ms. Augustin precluded from commencing a mediation proceeding by s. 55.2 of the *Schedule* because she did not attend an IE for which Unifund sent her a notice under s. 44?

The relevant portions of s. 55.2 read as follows:

> **55.** An insured person shall not commence a mediation proceeding under section 280 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.

This dispute arose because the parties disagreed from the outset about whether Ms. Augustin's injuries fell within the MIG. Under the 2010 *Schedule,* different procedures apply to the claiming and paying of medical benefits depending on whether the insured person suffered a minor injury to which the MIG applies. Section 40 applies to claims to which the MIG applies; s. 38 deals with treatment claims for injuries which, in the opinion of the insured person's health practitioner, are not predominantly minor injuries as defined in the MIG. There is a separate form to apply for medical benefits under each section. Ms. Augustin submitted her claim for medical treatment, in the amount of $2,934.90, under s. 38, on a Treatment and Assessment Plan form (OCF-18) dated July 4, 2011, as required by that section,[3] and on the basis of her practitioner's opinion that her injuries fell outside the MIG.

In response, Unifund sent Ms. Augustin two notices dated August 9, 2011. The first was in the form of an Explanation of Benefits. Unifund indicated the treatment expenses were not payable and advised her it required an IE to determine if her impairment was a minor injury within the MIG.[4] The second notice was a Notice of Examination to attend an IE under s. 44(5) to "confirm" if her accident-related impairment was a minor injury.[5]

Ms. Augustin refused to attend the IE, and Unifund denied her claim for medical treatment on the basis that she was "non-compliant." In total, Unifund paid $558.54 in treatment.[6]

Unifund sent two more notices to attend IEs, which Ms. Augustin again refused to attend. Unifund then brought this motion for a determination that Ms. Augustin was precluded by s. 55.2 from disputing her claims through the dispute resolution process.

Unifund's position is that on a plain reading of s. 55.2, Ms. Augustin *must* attend an IE once notified in accordance with s. 44. If she does not attend, she is precluded from commencing a mediation proceeding under s. 280 of the *Insurance Act,* and is prevented from disputing any of: 1) the adequacy of the IE notice; 2) whether the IE is reasonably necessary; or 3) the denial of benefits.

[3] OCF-18 dated July 4, 2011, Tab EE

[4] Tab Y. The Explanation of Benefits also stated that attendant care benefits were not payable for MIG injuries and that Unifund was "in the process of assessing" whether Ms. Augustin's injuries fell within the MIG.

[5] Tab FF

[6] Benefit Statement dated September 6, 2011 sent by Unifund to Ms. Augustin. The statement identifies the Benefit Exposure as $3,500 and a balance remaining of $2,941.16.

Ms. Augustin disagrees. She submits that under s. 55.2, Unifund's IE notices must first be "in accordance with this Regulation" – i.e. in accordance with s. 44(5) – before Unifund can rely on her non-attendance to deny her access to mediation. She maintains Unifund's notices did not comply with s. 44(5) of the *Schedule* because they failed to include "medical reasons" for requiring the IE's. She makes the same argument regarding Unifund's failure to provide her with "medical" or other reasons for refusing to pay for her treatment, contrary to s. 38(8) of the *Schedule*.

I agree. I find, on a plain reading of s. 55, that an insurer's notice to attend an IE that is "in accordance with" the *Schedule* is one of the circumstances specified in s. 55 that must exist before the insurer can rely on s. 55.2 to shut an insured person out of the mediation process under the *Insurance Act*. Furthermore, as s. 55.2 specifically refers to s. 44, which sets out detailed rules for IEs, and as the insurer's right to an IE is itself founded in s. 38(10) of the *Schedule*, I find insurers must comply with the notice requirements of both s. 38 and s. 44 before s. 55.2 can operate as a bar to mediation.

In this case, I find Unifund's notices did not comply with the requirements of either s. 38 or 44, for the reasons set out below.

Failure to give notice in accordance with s. 38(8) of the Schedule:

Section 38 sets out the mandatory steps each party must follow in non-MIG claims for treatment, and what an insurer must do if it wishes to challenge the opinion of the insured person's health practitioner that the person's injury falls outside the MIG. It also specifies the consequences to each party if the set procedures are not followed.

The first step is for the insured person's regulated health practitioner to submit a Treatment and Assessment Plan (OCF-18) which must include a statement that he or she is of the opinion that the proposed treatment and its cost are reasonable and necessary, and that the insured person's impairment is either not predominantly a minor injury, or it is, but falls outside the MIG because a pre-existing medical condition will prevent maximal recovery if the insured person's treatment

is limited to the $3,500 minor injury maximum.[7] According to the guideline itself, additional medical information is not necessarily required.[8]

Once a Treatment and Assessment Plan is submitted, the insurer must send the insured person a notice under s. 38(8) that identifies:

- the goods and services described in the treatment plan that the insurer agrees to pay for;
- any the insurer does not agree to pay for; and
- "the medical reasons and all of the other reasons why the insurer considers any goods or services, or the proposed costs of them, not to be reasonable and necessary."

In addition, under s. 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 person." [emphasis added].

Finally, under s. 38(11), if the insurer fails to give a notice in accordance with subsection 38(8), the insurer is prohibited from taking the position that the MIG applies and must pay for the goods and services claimed in the treatment plan.

For the reasons set out below, I find the notice Unifund purported to send Ms. Augustin under s. 38(8), in the form of an Explanation of Benefits, did not meet the requirements of either s. 38(8) or (9), and consequently Unifund must pay the $2,934.90 claimed.

Section 38(8) notice must advise that the insurer believes the MIG applies

On the Explanation of Benefits dated August 9, 2011, in the box entitled "Reasons why expenses are not payable", Unifund stated:

> Based on our review of the medical documentation provided to date, we require an assessment by an independent medical assessor, in order to determine if your

[7] s. 38(3).

[8] The MIG states, at p. 5, "Compelling evidence should be provided using the Treatment and Assessment Plan (OCF-18) with attached medical documentation, **if any**, provided by a health practitioner." [emphasis added.]

> impairment is predominantly a minor injury as described in the Minor Injury Guideline. Please see the Notice of Examination for further details.

I find this Explanation of Benefits does not comply with s. 38(8) because it does not state that Unifund "believes" the MIG applies, or why. Nor does it state the "medical reasons and all of the other reasons why the insurer considers any goods or services, or the proposed costs of them, not to be reasonable and necessary." In fact, it provides *no* reason, medical or otherwise, explaining why it is refusing to pay the benefit claimed.

I find Unifund's statement that it requires an IE to determine "if" the impairment is predominantly a minor injury to which the MIG applies does not meet the requirements of a s. 38(8) notice for two reasons: one, it is not a "medical" reason; and two, it is not the same thing as stating that it *believes* the MIG applies, which is what s. 38(9) requires and which is one of the grounds on which Unifund is entitled to an IE under s. 38(10). Although this might seem a very fine point, that is what the sections actually say. The legislature chose this wording, and recognised principles of statutory interpretation require me to interpret it in a reasonable fashion and in the overall context of the accident benefits scheme. Given that an insured person's treating practitioner must provide a factually based medical opinion to support a claim for treatment outside the MIG, I find it is reasonable to require an insurer who chooses to refuse to pay an initial claim to counter with something more than simply a desire "to determine if your impairment is predominantly a minor injury as described in the Minor Injury Guideline," as Unifund has done in this case. This is particularly so where, as in the case here, Unifund *refused to pay* for the treatment pending an IE, a response I find undermines the stated purpose of the MIG to provide access to early treatment, a purpose based on sound medical principles.

In any event, I find that stating a belief that the MIG applies is not, by itself, a sufficient reason for refusing to pay a claim for treatment because at that point in the process, the insurer has not yet had an opportunity to assess the claim, a right it has under s. 38(10) in the form of an IE. The insurer has only its "belief" that the MIG applies. If an unexplained belief – a belief without reasons – were the only requirement for refusing treatment claims, an insurer could simply refuse to pay any non-MIG treatment claim on principle; require an insured person to attend an IE; and withhold payment until the person attends and the report has been received.

This is an unacceptable outcome, given the emphasis on early treatment of accident injuries in the MIG. In fact it defeats the purpose of the MIG on two fronts. Firstly, even if the IE ultimately determines the injury is a minor one, the insured person who could not pay for the treatment out of their own pocket might have to go without early treatment until the determination is made. Secondly, it increases the likelihood of insurers requiring IEs to challenge initial claims for treatment, which defeats the legislature's goal to deal with and limit the increasing costs of IEs.[9]

Finally, as regards an insurer's statement that it believes the MIG applies, I find this is not itself a "medical reason," nor is it subsumed under that term. It is a separate and different reason under a different subsection – s. 38(9). Including it as a reason for not paying the benefit claimed does not relieve an insurer from the obligation to include in its s. 38(8) notice the "medical and other reasons" *why* it considers the treatment claimed not to be reasonable and necessary (and, consequently, not payable).[10]

I find, therefore, as part of the s. 38(8) notice, an insurer must have reason to support its belief that the MIG applies, and must include its reasons in the notice. As the subsection states, these must be "medical and any other reasons."

Section 38(8) notice must include medical reasons; IE no longer mandatory

The requirement to include medical reasons in a notice explaining whether a medical benefit will be paid is new to the SABS-2010. The previous s. 38(8) did not require the insurer to provide any reasons at all for refusing to pay for treatment, but did require an IE if treatment was refused.[11] That is no longer the case.

Unfortunately, however, neither the *Schedule* nor the MIG contains a definition of the term medical reasons, or clearly explains why it was added, or why an IE under s. 38(10) is now at the insurer's discretion rather than mandatory, as before.

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[9] Unifund raised the concern in its submissions and relied on the Submission to the Standing Committee on Finance and Economic Affairs, FSCO July 9, 2012, Tab MM.

[10] That is not to say that there may not be in some cases non-medical or "other" reasons for refusing to pay a benefit; a missing claimant signature on a treatment plan, for example.

[11] Or if the insurer believed the *Pre-approved Framework Guideline for Whiplash Associated Disorder Grade II Injuries With or Without Complaint of Back Symptoms* − Superintendent's Guideline No. 04/07, June 2007) applied: s. 38 1. A iii. and 2. A.

When viewed in the context of the MIG and the legislature's intent to reduce examination costs, however, the new requirement for more fulsome reasons for refusing to pay for treatment in the early stages of the claims process begins to make sense.

The MIG states that "The SABs and this Guideline are intended to encourage and promote the broadest use of this Guideline" by "all stakeholders." Given the importance the legislature has placed on the MIG, and on the initial medical opinion of the insured person's treating health practitioner about whether the insured person's injury falls outside the MIG, I find that an insurer, to satisfy the requirement to provide medical reasons, must refer to both the MIG and to the treating health practitioner's opinion if it chooses not to pay for treatment pending an IE to determine if the MIG applies or if the treatment claimed or cost thereof is reasonable and necessary.

The MIG further states that "An insured person's impairment does not come within this Guideline if the insured person's impairment is predominantly a minor injury but, based on **compelling evidence** provided by his or her health practitioner, the insured person has a pre-existing medical condition that will prevent the insured person from achieving maximal recovery from the minor injury if he or she is subject to the $3,500 limit referred to in s. 18(1) of the SABS or is limited to the goods and services authorized under this Guideline." [emphasis added]

The MIG further states that "Compelling evidence should be provided using the Treatment and Assessment Plan (OCF-18) with attached medical documentation, **if any**, provided by a health practitioner." [emphasis added]

These paragraphs are consistent with the legislature's intent to reduce the cost of unnecessary IEs by requiring insurers to use their judgment in applying the MIG to medical information provided by the treating health practitioner, in order to determine whether or not to pay for items submitted in an initial treatment and assessment plan.

However, these requirements, as expressed in the MIG, do not, despite their intention, appear to be particularly helpful to either the person preparing the treatment plan or the person who must decide whether to pay for it – the claims adjuster. Compelling evidence of a pre-existing injury is required to take a person out of the MIG; the person's health practitioner must provide such compelling

evidence from the outset; compelling evidence is not defined; and medical documentation supporting the compelling evidence is only required if it is available.[12] Nevertheless, the claims adjuster must decide whether to pay for initial treatment based on the criteria in the MIG as applied to the Treatment and Assessment Plan before him or her, and provide medical reasons for his or her decision.

I find it follows logically from these requirements that in its s. 38(8) notice to the insured person that medical benefits will not be paid, the insurer, in explaining why the benefits are not payable, must indicate that it has reviewed the Treatment and Assessment Plan and any medical documentation provided; compared it to the criteria in the MIG; 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). I find that type of response would meet the insurer's obligation to provide "medical reasons" as required by s. 38(8) when it chooses to refuse benefits because it believes the MIG applies.

The requirement to provide medical reasons also eliminates the expense of an automatic initial IE. This is consistent with s. 38(10), which allows for an IE at the discretion of the insurer. It is also consistent with s. 44(3)(a), which provides that the right to a discretionary IE does not apply with respect to a benefit payable in accordance with the MIG. When read together, these sections only make sense if one allows that, under the new *Schedule,* an insurer may choose to determine that the treatment claimed is only payable under the MIG (regardless of the opinion of the treating health practitioner); refuse to pay for the treatment; and choose to forego its right to an IE. That leaves the insured person the option of accepting the insurer's determination, and treatment under the MIG, or disputing it by applying for mediation. I find that by imposing the more onerous requirement upon insurers to provide medical reasons if they believe the MIG applies and they choose to refuse to pay for treatment, the 2010 *Schedule* makes insurers accountable for any initial decision that limits or denies initial treatment. The requirement to provide medical reasons prevents insurers from deciding to refuse treatment arbitrarily or on principle.

[12] See Footnote #8

I do not agree with Ms. Augustin's suggestion that the term "medical reasons" in s. 38(8) (or in s. 44(5), for that matter, discussed below), means reasons based on the opinion of a health practitioner, or that insurers should hire in-house medical staff to conduct an initial paper review. A medical reason is not the same thing as a medical opinion. A medical opinion, such as that required of the health practitioner who submits the Treatment and Assessment Plan, is based on facts obtained from an assessment of the insured person's medical condition, in person or otherwise. As stated above, an insurer does not have the benefit of its own medical opinion at the time it receives the initial treatment plan, and can only obtain one by exercising its right to an IE, founded in s. 38(10), and for which rules are set out in s. 44(5).

As for what constitutes compelling evidence, I agree with Arbitrator Wilson in *Scarlett and Belair*[13] that compelling evidence likely means credible or believable evidence.[14] However, this can often only be determined on hindsight, after considering the medical evidence and opinions of both the insured person's health practitioner and the insurer's IE assessor. In other words, the insurer is entitled to be wrong in its initial, pre-IE determination that an insured person has not presented compelling evidence that his or her injury falls outside the MIG.

I also do not agree with Unifund's submission that the need for a first medical opinion in the form of an IE is itself sufficient to satisfy the definition of a medical reason. If that were so, there would be no point to the change in wording from the previous *Schedule*. Also, it is inconsistent with the discretionary nature of an IE under the new *Schedule*.

In this case, Unifund submitted at the hearing that it refused to pay for the treatment recommended in Ms. Augustin's Treatment and Assessment Plan because it did not have enough medical information to determine if the MIG applied. Unfortunately, that is not what it told her in its Explanation of Benefits. Nor did Unifund state that Ms. Augustin's treating practitioner had failed to provide compelling reasons to explain why the MIG should not apply. By failing to include these medical reasons in its response, I find Unifund's s. 38(8) notice was defective.

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[13] *Scarlett and Belair Insurance Company Inc.* (FSCO A12-001079, March 26, 2013)

[14] I do not agree, however, that the insurer bears the onus of proof at this initial stage, because at that point the insured person has had the benefit of a medical opinion, and the insurer has not, and will not, until it exercises its right to an IE. In any event, *Scarlett* is under appeal.

Consequences of failure to give notice in accordance with s. 38(8) of the Schedule:

There are two consequences to Unifund in this case due to its failure to provide a notice that complied with the requirements of s. 38(8).

The first is that it cannot rely on s. 52.2 to preclude Ms. Augustin from commencing a mediation proceeding until she attends an IE. As stated earlier, this is because a refusal to pay a benefit must be in the form of a notice that complies with s. 38(8), and it is the refusal to pay the benefit claimed, or a belief that the MIG applies, that give rise to the right to an IE under s. 38(10).

The second consequence is spelled out in s. 38(11), which states that if an insurer fails to give a notice in accordance with subsection (8), it is prohibited from taking the position that the MIG applies, and it shall pay for the goods and services described in the treatment and assessment plan until it gives the proper notice. As I find Unifund did not give Ms. Augustin a proper notice with reasons for refusing to pay for the medical treatment she claimed in its August 9, 2011 Explanation of Benefits, I find s. 38(11) applies and Unifund is required to pay the $2,934.90 claimed.

Failure to comply with 44(5) of the Schedule:

Under s. 44(1) of the *Schedule*, an insurer is entitled to an IE for the purpose of assisting it "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 . . . ."

Under s. 44(5), an insurer who requires an IE must give the insured person a notice that sets out, among other things, "the medical and other reasons for the examination."

Unifund's Notice of Examination dated August 9, 2011 (the first of three), for an IE to take place on August 26, 2011 indicated that the IE related to "Medical and Rehabilitation Benefits," and the "Applicability of Minor Injury Guideline," with the reasons for the examination described as follows:

> As the treatment and assessment costs received to date are in excess of the minor injury coverage limit of $3,500.00, we require an assessment by an independent medical assessor in order to confirm if your accident related impairment is a minor injury and to determine if the goods and services being proposed are reasonably required as a result of the accident and we require an assessment by an independent medical assessor, in order to determine if treatment (OCF-18, July 4,'11 $2,934.91) would be reasonably required as a direct result of the motor vehicle accident.[15]

The requirement to include medical reasons in an IE notice, as distinct from "other" reasons, is also new to the SABS-2010. The previous s. 42(4)(a) required only that an IE notice include "the reasons for the examination."[16]

As stated above, I find s. 38 and s. 44 must be read together, as the right to an IE is founded in s. 38(10) and arises from the insurer's right under s. 38(8) to refuse a claim for treatment. I have already identified that the "medical reasons and all of the other reasons" in the refusal notice should include, at a minimum, a statement that the claims adjuster has reviewed the MIG and the treating health practitioner's medical opinion, and 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 reasonable or necessary. The "medical and other reasons for the examination" in the Notice of Examination under s. 44(5) should contain substantially similar information.

Unifund's IE notice, above, does not reflect these additional requirements and so does not comply with the *Schedule.*

Given the serious consequences to an insured person of refusing to attend an IE for which proper notice has been given – barred from commencing a mediation proceeding to dispute an insurer's denial of medical treatment – the notice requirements set out in s. 44(5) should be strictly construed and the insurer's notice should be closely examined to ensure it complies. The requirements are mandatory. They are there to balance the naturally intrusive nature of an IE and to ensure fairness. The insured person is entitled to make an informed decision about whether they

[15] Unifund's Factum, Tab FF. A September 6, 2011 Benefit Statement issued by Unifund (Unifund's Factum, at Tab Z) listed the medical and rehabilitation coverage limit under the MIG as $3,500, with $558.84 paid to date, and the balance remaining as $2,941.16. It is not clear when the $558.84 was paid.

[16] The only other significant difference between the former ss. 42(4) and the current 44(5) is that 42(4)(b) required the IE notice to state the type of examination to be conducted, whereas s. 44(5) does not contain that requirement.

wish to pursue their claims and attend the IE, or not. The legislature has determined that, in fairness, an insured person is entitled to specific information, including medical reasons, about why they are being required to attend an IE. I find it would be unreasonable and unfair to require them to attend without first being in possession of that information.

The insured person's decision not to attend an IE because the notice was not in accordance with the *Schedule* is not without risk of significant consequence. If it is ultimately determined that the IE notice was valid, and that the IE was reasonably necessary (another *Schedule* requirement with which the insurer must comply, discussed below), it is then, and only then, that the intended consequence of s. 55 will take effect: the insured person will not be able to mediate the claims the IE was intended to address unless he or she attends the IE.

In this case, I find Unifund did not comply with s. 44, and so s. 55.2 does not apply.

Must an IE be reasonably necessary?

As part of its position that failure to attend an IE is a bar to mediation under s. 55.2, Unifund submitted that an insured person can no longer dispute any aspect of an IE request, including whether the IE was reasonably required. Unifund's reasoning is that the change in wording from the previous s. 55(b)[17] means there is no longer any obligation under the current scheme that an IE be reasonably necessary, and this change reflects the legislature's intention to deal with the rising costs associated with IEs and litigation of non-attendance issues. Unifund further submits that, as there is no longer any opportunity for applicants to challenge whether an IE is reasonably necessary, arbitral and court jurisprudence on that issue no longer applies.

I find Unifund's position to be without merit, for a number of reasons.

The first is that I do not agree that a plain reading of s. 55 means that an applicant can no longer dispute whether an IE required under s. 44 is reasonably necessary. I have found that before an insured person's non-attendance at an IE can operate as a bar to mediation, the insurer's notice must comply with the requirements of s. 44. Section 44(1) provides that insurers are entitled to IEs to

[17] In force prior to July 1, 2011

determine initial or ongoing entitlement to benefits, "not more often than is reasonably necessary." I find it self-evident that by referring specifically to s. 44 in s. 55, the legislature intended to continue to limit insurers to IEs that occur "not more often than is reasonably necessary."

Given the inclusion of s. 44 in s. 55 and the well-established jurisprudence on the issue of the reasonable necessity of IEs, it would seem implicit that insurers remain subject to oversight about whether an IE is reasonably necessary, and I find the language in s. 55 does nothing to change that. The only way for an insured person to ensure such oversight takes place is through the dispute resolution process that begins with an application for mediation. I see nothing in the language of either s. 44 or s. 55, read together, that suggests Ms. Augustin should be prevented from having a dispute about whether an IE is reasonably necessary determined by an arbitrator, because she did not attend an IE.

The second reason I do not agree with Unifund's interpretation is that it is too broad. If it were correct, insurers could require any number or type of IEs they liked, no matter how often, or how unreasonable, without oversight or consequence, and insured persons would be forced to attend on pain of permanently jeopardizing their benefits and any right to dispute the reasonableness of the IE, without any recourse at all.

Such an interpretation strays too far from an insurer's obligation of utmost good faith in a first party system and the standard of consumer protection set by cases such as *Smith v. Co-operators*[18] and years of court and arbitral jurisprudence. It is not tenable.

I find in this case that Ms. Augustin's failure to attend an IE does not preclude her from a determination of whether the IE requested by Unifund was reasonably necessary.

Was Unifund's IE reasonably necessary?

I have found that Unifund's Explanation of Benefits stating Ms. Augustin's treatment was not payable did not comply with s. 38(8). The *Schedule* provides a specific remedy in this circumstance: the benefits are to be paid. I have applied that remedy. The question of whether the IE was reasonably required is no longer relevant.

[18] *Smith v. Co-operators General Insurance Co*. [2002] 2 S.C.R. 129

Should Ms. Augustin be precluded from pursuing a claim for non-earner benefits because those benefits were never applied for, in accordance with the requirements of s. 55 of the *Schedule*?

Ms. Augustin's Application for Accident Benefits (OCF-1) indicated she was unemployed at the time of the accident and was caregiver to two children aged 14 and 5 years old. As Ms. Augustin had not purchased optional coverage for caregiver benefits under her policy of insurance, she was not entitled to a caregiver benefit.

The only weekly benefit for which Ms. Augustin might be eligible under the *Schedule* was the non-earner benefit (NEB) of $185 per week, which is only payable 26 weeks after the accident, and only if, at 26 weeks post-accident, the insured person's accident impairments render her completely unable to carry on a normal life.

Dr. T. Bui, Ms. Augustin's treating chiropractor, submitted a Disability Certificate (OCF-3) to Unifund dated July 4, 2011, indicating Ms. Augustin was completely unable to carry on a normal life, defined as having "sustained an impairment that continuously prevents the person from engaging in substantially all of the activities in which [she] ordinarily engaged before the accident." [19] Dr. Bui estimated the duration of Ms. Augustin's disability as 9-12 weeks.

In response to Ms. Augustin's OCF-1 and OCF-3, Unifund sent Ms. Augustin an Explanation of Benefits (OCF-9) on August 9, 2011 explaining why she was not entitled to an income replacement, caregiver or non-earner benefit. Regarding the NEB, the explanation read:

> There is no entitlement to weekly non-earner benefits for 26 weeks after the onset of a complete inability to carry on a normal life as per Section 12 of the Statutory Benefits Schedule. If there is any medical documentation regarding your disability, please submit as soon as possible.[20]

Unifund's position is that it is not required to pay Ms. Augustin an NEB because she never applied for it, and Ms. Augustin is precluded from mediating this issue under s. 55(a) of the *Schedule*, for the same reason.

[19] He also indicated she met the substantial inability tests to qualify for caregiving and housekeeping benefits, but Ms. Augustin had not purchased the optional coverage for either of those benefits.

[20] This language is not accurate. The NEB is not *payable* for 26 weeks, regardless of eligibility.

I reject this argument for a number of reasons. The first is that I find the OCF-1 and OCF-3 Ms. Augustin submitted to Unifund together satisfy the requirement of notifying the insurer of an intent to apply for a benefit under sections 32(1) and (5) of the *Schedule.* The second reason is that I find it was up to Unifund to properly adjust Ms. Augustin's claim for an NEB by exercising its right to determine her continuing entitlement to the benefit under s. 37(1), and in failing to do so it cannot now raise the "defence" that she never applied for the benefit.

I find it evident that the OCF-1 submitted by Ms. Augustin is the "completed and signed application for benefits" referred to in s. 32(5) of the *Schedule,* and that Ms. Augustin submitted it in a timely fashion.

The OCF-1 indicated Ms. Augustin was an unemployed caregiver. As she had not purchased the optional caregiving benefits, the only potential weekly benefit for her would be an NEB. It is evident on the face of the OCF-1 form that the information applicants and their health care providers are required to supply about the applicant's status (employed, unemployed, student or caregiver) is for insurers to determine which weekly benefit would potentially apply.[21] For example, Part 6 of the OCF-1 asks specifically if the applicant was attending school full-time or if they had completed their education less than one year before the accident – a question which directly addresses entitlement to an NEB on those grounds as set out in ss. 12(1)2.(i) and (ii) of the *Schedule*. The questions about employment and caregiver status serve the same function regarding potential entitlement to any of the three types of weekly benefits.

The OCF-3 provided by Ms. Augustin's health practitioner indicated his opinion that she met the complete inability test for non-earner benefits in the 9-12 weeks after the accident. I find this meets the requirement under s. 36(2) that "an applicant for a specified benefit[22] shall submit a completed disability certificate with his or her application under section 32."

As there is nothing in the *Schedule* to indicate Ms. Augustin is required to re-submit a claim for an NEB after the 26-week waiting period, I find, in this case, because her health practitioner

[21] Assuming the applicant meets the applicable disability test.

[22] Defined under s. 36(1) as an IRB, NEB, caregiver benefit or a payment for housekeeping or home maintenance services.

indicated she met the non-earner test when the OCF-3 was filed, the initial OCF-1 and OCF-3 trigger the Insurer's obligation under section 37 to determine Ms. Augustin's continuing entitlement to the NEB at the 26-week mark. Section 37 requires an insurer to do one of the three things if it wishes to determine continuing entitlement: a) request an updated disability certificate; notify Ms. Augustin that it required an insurer's examination (IE) under s. 44; or c) do both. Unifund did none of these things.

This interpretation is consistent with the overall purpose of the *Schedule*, which is to determine claims promptly, and with sections 36 and 37 in particular, which set out certain rules about claiming and paying "specified benefits," which include NEBs. The other "specified benefits" are IRBs, caregiver, and housekeeping expenses. Both applicants and insurers must follow these rules. Section 36 applies to initial claims for the specified benefits, and section 37 to continuing entitlement to those benefits.

The rules are consistent in both situations and impose similar obligations on insurers to take steps to adjust the claims for those benefits. Had Ms. Augustin's OCF-1 and OCF-3 indicated potential entitlement to either an IRB or caregiver benefit, for example, Unifund would initially have had to exercise one of its options under 36(4) within 10 days: (a) pay the benefit; (b) explain the medical reasons for not paying or require an IE under s. 44; or (c) request more information under s. 33(1) or (2).

As noted, under s. 37, to determine continuing entitlement to a specified benefit, I find it was up to Unifund to either request an updated OCF-3 or notify Ms. Augustin that it required her to attend an IE under s. 44. There is nothing in the *Schedule* that either requires Ms. Augustin to reapply for the benefit, or that entitles Unifund to simply sit back and do nothing, just because the NEB is subject to a 26-week waiting period. The lack of a clear process in the case of NEBs would appear to be an anomaly, given the prescriptive nature of the *Schedule* overall, and I find that to allow Unifund to use that to its advantage in this case would be inconsistent with the positive obligations imposed on insurers to take steps to promptly determine initial and continuing entitlement to specified benefits and the tools provided for them to do so under sections 36 and 37.

I reject Unifund's alternative argument that it is not required to pay an NEB because Ms. Augustin did not submit an election for the benefit under s. 35. Under s. 35, if an application indicates that the applicant may qualify for **two or more** of the IRB, caregiver or NEB benefits, the insurer must advise the person that she must elect which benefit she wishes to receive. As Unifund concedes, Ms. Augustin could only qualify for one benefit – the NEB. Although this may relieve Unifund of its obligation to require Ms. Augustin to elect a benefit, it does not necessarily follow that it can require her to reapply for the NEB after 26 weeks.

It appears the only information Unifund sent Ms. Augustin regarding her entitlement to an NEB inaccurately advised her that there was "no entitlement to weekly non-earner benefits for 26 weeks after the onset of a complete inability to carry on a normal life." This information was inaccurate – an NEB is not *payable* for the first 26 weeks. It was also unhelpful because it does not advise Ms. Augustin whether or not she was expected or required to reapply for the benefit after 26 weeks. For example, even if there were such a requirement, it falls short of the standard of consumer protection required of insurers since *Smith v. Co-operators* and I find Unifund cannot take the position that it is not required to pay an NEB because Ms. Augustin did not "apply" for it.

EXPENSES:

As Ms. Augustin has been successful in this preliminary issue hearing, I exercise my discretion to award her her expenses incurred in this proceeding. If the parties are unable to agree on the amount of expenses, I will determine the matter by way of written submissions to be received no later than 30 days from the date of this decision.

November 13, 2013

Susan Sapin
Arbitrator

Date

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A12-000452

BETWEEN:

KADIAN AUGUSTIN

Applicant

and

UNIFUND ASSURANCE COMPANY

Insurer

ARBITRATION ORDER

Under section 282 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, it is ordered that:

1. Ms. Augustin is not precluded from commencing a mediation proceeding by s. 55.2 of the *Schedule.*

2. Ms. Augustin is not precluded from pursuing or mediating her claim for a non-earner benefit under the *Schedule.*

3. Unifund shall pay to Ms. Augustin treatment expenses of $2,934.90 as claimed, together with interest under s. 51(2) of the *Schedule.*

4. Unifund shall pay to Ms. Augustin her expenses of this preliminary issue hearing, as agreed or assessed.

November 13, 2013

Susan Sapin
Arbitrator

Date