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INSURANCE LAW BULLETIN

October 2, 2013 – Rose Bilash, Hermina Nuric and Evan Bawks

IMPLICATIONS OF RECENT CHANGES TO THE *STATUTORY ACCIDENT BENEFITS SCHEDULE* – O.Reg 34/10

This Bulletin will provide an overview with respect to amendments to the *Statutory Accident Benefits Schedule* – 34/10 (the "new" *SABS*) which came into effect on July 1, 2011 and June 1, 2013. The majority of the amendments are intended to combat fraud in the accident benefits industry. The 2013 amendments in particular purport to implement four of the 38 recommendations from the Auto Insurance Anti-Fraud Task Force Final Report of October 16, 2012.

On July 1, 2011, the legislature introduced two new provisions to the *SABS* which allowed insurers to challenge invoices for goods and services suspected to be fraudulent. These provisions permitted the insurer to request additional information and documentation from the provider(s) of the goods and/or services.

On June 1, 2013, the legislature introduced three Regulations amending the *Insurance Act*, which included further amendments to the *SABS*, an additional offence under the *Unfair or Deceptive Acts or Practices* Regulation and an amendment to the *Disputes Between Insurers* Regulation.

July 1, 2011 Amendments

Ontario Regulation 194/11 introduced provisions 46.1 and 46.2 to the new *SABS* as well as an additional subsection under s.55. The new provisions stated the following:

> 46.1 In this Part,
>
> "provider" means,
>
> (a) a person who submits an invoice to an insured person or insurer for payment under this Regulation for goods or services, whether the goods or services were provided by the person or by another person, and
>
> (b) a person, other than the person who submits the invoice described in clause (a), who provided any of the goods or services referred to in the invoice.

Duty of provider to provide information

46.2 (1) An insurer may request any of the following information from a provider:

1. Any information required to assist the insurer, acting reasonably, to determine its liability for the payment, including access to inspect and copy the originals of any treatment confirmation form, treatment and assessment plan, assessment of attendant care needs and other documents giving rise to the claim for payment.

2. A statutory declaration as to the circumstances that gave rise to the invoice, including particulars of the goods and services provided.

3. In the case of a provider described in clause (a) of the definition of "provider" in section 46.1,

i. the name and full municipal business address of the provider and of every provider described in clause (b) of that definition, and
ii. ii. proof of the provider's identity and of the identities of every provider described in clause (b) of that definition.

(2) The provider shall give the insurer the information requested under subsection (1) within 10 business days after receiving the request.

(3) For the purpose of section 51, the amount payable by an insurer under an invoice is not overdue and no interest accrues on it during any period during which a provider fails to comply with subsection (2).

Provision (a) applies to parties that are authorized to submit invoices directly to the insurer, including regulated health professionals, rehabilitation centres and other facilities that have the authority to prepare Auto Insurance Standard Invoices (OCF-21 forms) or to submit invoices to the insurer through the HCAI system.

Provision (b) casts a much wider net. It captures individuals who provided goods or services under the supervision of a regulated health professional in whose name an invoice is submitted (such as a massage therapist or psychological associate for example). It also captures multiple providers that are listed in a single treatment and assessment plan. In addition, the definition of "provider" appears to be sufficiently broad to include individuals who are providing housekeeping, caregiving or attendant care services given that their services are typically not billed to the insurer directly but rather, submitted via an OCF-6 in the name of the insured.

Section 46.2(1) outlines the kind of information that may be requested from a provider. Paragraph 1 contains broad language, including "any information required to assist the insurer" and "other documents giving rise to the claim for payment". The insurer appears to be empowered to request any piece of information or documentation that it can reasonably show to be relevant to its determination of liability to pay an invoice. This may be particularly helpful when dealing with treatment and assessment plans that contain minimal information. For example, an examiner may find it necessary to clarify the nature of a treatment modality. The benefit of treatment is also often not evident, particularly where seemingly identical treatment and assessment plans continue to be submitted by the provider. This section should also be

used to request attendance sheets and the clinical notes and records of the provider(s) in order to verify that an invoice correlates with the treatment or service provided.

The ability to inspect original treatment and assessment plans and treatment confirmation forms is significant in situations where the insurer suspects that the treatment and assessment plan was not signed by the injured claimant, or even where the insurer suspects that a regulated health professional's signature may have been used without authorization (for example, where electronic signatures of former employees/contractors were retained).

With respect to paragraph 2, it is significant to note that statutory declarations have the same force and effect as if they were made under oath. The added legal implications of declaring false information may serve to discourage false claims, particularly by lay providers of housekeeping and home maintenance services or attendant care services. The term "particulars" has, in the past, been described to include any "reasonable information of the allegations upon which [claimant] maintains his entitlement": *Wahidpur v. Unifund Assurance Co.*, [2007] O.F.S.C.D. No. 133. The term can potentially capture any information that the insurer can show to be reasonably related to the claimant's entitlement to a benefit.

The ability to request a statutory declaration directly from providers further helps the insurer access information that is not within the personal knowledge of the injured claimant. For example, the insurer may require a declaration about inconsistencies between the information contained in a chiropractor's notes and the services the chiropractor has invoiced. A statutory declaration should also be demanded from lay providers (friends or family submitting housekeeping, caregiving or attendant care expenses) whose alleged services do not accord with information provided by surveillance or other information.

Requesting proof of identify as outlined in paragraph 3 will be useful in situations where the insurer suspects that a service provider's name is being used without his or her permission. Additionally, where an insurer is unable to verify a treatment provider's professional membership or affiliation, it will be able to request proof from the provider.

Time Frame for Responding

The timeframe for responding to the insurer's request is 10 business days after receipt of the request. If the request for information is served by regular, registered or certified mail, service will take place on the fifth business day after the date the post office stamps the mailed document. If the request is faxed before 4:45 p.m., it will be deemed to have been received on the same day, as per the *Dispute Resolution Practice Code*.

When calculating the due date for the response of lay providers, it is important to remember that a provider is not necessarily represented by the claimant's lawyer, even if his or her invoices were submitted to the insurer through the lawyer's office. Service of the request on the claimant's lawyer will therefore not be deemed to be service on the provider.

What are the consequences of failing to respond to the request?

If the provider does not comply with the request within the 10 business day period, section 46.2(3) states that the amount payable by an insurer under an invoice is not overdue and no interest accrues on it during any period during which a provider fails to comply with subsection (2). With respect to the issue of interest, section 46.2(3) is superior to the consequences outlined in section 33(8) as section 33 does not suspend interest. However, section 33(6) does

permit the insurer to suspend the benefit to which the requested information relates. Although it may be open to the insurer to make its request for information under both section 46.2 and section 33(1) as this would provide the insurer with the ability to suspend the benefit yet avoid the accrual of interest while the information remains outstanding, this is not a strategy we would recommend. Arbitral jurisprudence has firmly established that an insurer's request under section 33 must be within the control of the insured to provide. We do not anticipate an arbitrator would suspend an insured's benefits because of a provider's noncompliance with section 46.2.

Section 55 has also been amended to prevent a claimant from commencing a mediation proceeding if the information requested under section 46.2(a) is not provided. As with any preliminary section 55 defence, arbitrators are generally hesitant to take away a claimant's right to mediation. Arbitrators have started to adopt a fairness based approach that recognizes that the arbitration process is adversarial in nature, and that an insurer that has acted reasonably has a right to a fair hearing that is not compromised by an inability to obtain evidence in support of its position. As a remedy, arbitrators have ordered that arbitration proceedings be stayed or adjourned in order to allow an insurer sufficient time to obtain the information or documentation it requires with respect to the issues in dispute.

Finally, we would note that while the provider technically may not be legally bound by the provisions of the *SABS,* failure to comply with the insurer's request will result in non-payment, which the insurer is legally allowed to do. Through the operation of these provisions, the fact that an insured is legally bound by the *SABS* but the providers are not may be a moot distinction; since the power of the regulation lies with the insurer to refuse payment on non-compliance, legitimate providers are *practically* bound by the *SABS*.

June 1, 2013 Amendments

The Insurance Act was recently amended by O.Reg 14/13, O.Reg 15/13 and O.Reg 16/13.

O.Reg 14/13 introduced certain changes to the *SABS*, including a requirement for insurers to provide *all* reasons when denying claims; providing FSCO with authority to stipulate additional information that insurers must provide in bi-monthly benefit statements to claimants; giving insurers authority to require claimant confirmation of receipt of good and services that have been billed; and, providing FSCO with authority to stipulate by Guideline the maximum payable by insurers for goods as well as services.

O.Reg 15/13 introduced changes to the *Unfair or Deceptive Acts or Practices* Regulation ("*UDAP*") including an offence to request, require or permit a claimant to sign an incomplete claim form. It is clarified that lawyers and paralegals are subject to *UDAP* offences only when they not acting in a legal capacity.

O.Reg 16/13 amends section 6 of the *Dispute Between Insurers* Regulation to allow insurers to conduct an examination under oath strictly for the purpose of resolving priority disputes.

O.Reg 14/13: *SABS*

(a) Duty of Insured to Provide Information

A new subsection was added to the *SABS*: s.46.3, which allows the insurer to request additional information from an insured person who submits an invoice for the payment of goods or

services with respect to the particulars as to “when, where and by whom” the goods or services were provided.

The new section 46.3 states as follows:

> (1) An insurer may request any of the following information from an insured person who submits an invoice to the insurer for payment for goods or services under this Regulation, or from an insured person on whose behalf such an invoice is submitted:
>
> 1. Confirmation in writing that the goods or services were provided to the insured person.
>
> 2. A statutory declaration as to the circumstances that gave rise to the invoice, including particulars as to when, where and by whom the goods or services were provided.
>
> (2) The insured person shall give the insurer the information requested under subsection (1) within 10 business days after receiving the request.
>
> (3) For the purpose of section 51, the amount payable by an insurer under an invoice is not overdue and no interest accrues on it during any period during which an insured person fails to comply with subsection (2).

Section 46.3 empowers the insurer to request information *directly* from the insured person, even if the invoice was submitted on that person’s behalf by someone else. This may be particularly useful where the insurer suspects that the insured person is unaware that a treatment facility has submitted various treatment and assessment plans on his or her behalf, or where the insurer suspects that the insured person may not have received the invoiced goods or services (including housekeeping, attendant care or caregiver services).

The “particulars” outlined in subsection (1)2 appear to be restricted to the questions of when, where and by whom the goods or services were provided. We do not expect the amendment was intended to burden an insured with the task of verifying the time consumed by a healthcare provider while writing a report, filling out a form, arranging the delivery of equipment or analyzing and scoring as assessment tool. The insurer, however, can rely on section 46.2 described above to request supplemental information that it may require directly from the service provider.

The timeframe for responding to the insurer’s request is 10 business days after receipt of the request. The request can be served on the insured person directly or through his or her solicitor. If the request is mailed, it will be deemed received on the fifth business day after the day it was stamped by the post office. If it is faxed to the insured person’s solicitor before 4:45 p.m., it will be deemed to have been received on the same day, per *Dispute Resolution Practice Code*.

The invoice will not be overdue and no interest will accrue on the invoice during any period of time during which the insured person fails to comply with the request.

Section 55 has unfortunately not been amended to give the insurer a preliminary defence if the insured person fails to comply with the request under section 46.3. It should be noted, therefore, that the failure of the insured to comply with section 46.3 does not prevent mediation, while failure of a provider to comply with section 46.2 does. This puts the onus on the claimant to retain a provider that will cooperate with their insurer.

(b) Denying Medical and Rehabilitation Claims

Subsection 38(8) of the Regulation has been amended by striking out "the medical and any other reasons why the insurer considers any goods, services, assessments and examinations, or the proposed costs of them, not to be reasonable or necessary" at the end and substituting "the medical reasons and all of the other reasons why the insurer considers any goods, services, assessments and examinations, or the proposed costs of them, not to be reasonable and necessary".

It is interesting that the legislators only amended section 38(8) which deals with medical and rehabilitation claims. This would suggest that there are now two standards for denying claims. It remains to be seen how arbitrators will address the dual standards.

The amendment to s.38(8) was based on concern by the Anti-Fraud Task Force that insurers were denying payments of medical and/or rehabilitation benefits without providing adequate reasons for the denial, for example, by providing a non-specific explanation such as "not reasonable or necessary". Medical and rehabilitation service providers claim that the abuse of victims has increased with the removal of the mandatory IE process and the addition of discretion on the part of the insurer in denying a claim. Ironically, these same providers who advocated for clearer language in the *SABS* also feel that the new wording makes no difference in terms of the interpretation of s.38(8).

We believe, however, that substituting "any other reasons" with "all of the other reasons" is a substantial difference. It suggests that the insurer must fully consider and precisely state the basis for its denial of a claim. We expect that claimant's counsel will attempt to rely on section 38(8) to limit the admissibility of any evidence outside of the insurer's stated reason(s).

The new language may also hamper an insurer's ability to address questionable claims without divulging investigations that may be in the preliminary stages. The fall-out is that, absent full disclosure of *all* the reasons for denying a claim, the insurer may be estopped from relying on additional reasons (as they materialize through ongoing investigation) at the time of arbitration or litigation.

The most prudent course for the insurer may be to list only those reasons that are fully established and/or conclusive at the time the denial is being made (such as an insurer's examination that finds a treatment plan not reasonable or necessary). Surveillance, on the other hand, can be regarded as only one piece of information, no matter how compelling, and therefore not conclusive.

Whether surveillance has in fact influenced the insurer's decision to deny a treatment plan may require additional, careful consideration. In the simplest case, the insurer would have provided its IE assessor with a copy of the surveillance, to review with the claimant following the assessor's examination. However, in most cases, the insurer will receive a number of treatment and assessment plans following a course or two of surveillance that shows an insured to be quite active with no visible signs of impairment. If the insurer does not have intentions of disclosing the surveillance, we believe that listing it as a basis for denying a claim potentially entitles the insured to a copy of the surveillance; an entitlement the insured would not have otherwise had at the time.

Another concern arising from the new language in s.38(8) is whether a denial is incomplete and/or improper if "all" the other reasons are not listed. It is well established in arbitral jurisprudence that an improper denial is the equivalent of no denial. In those circumstances, the limitation period will not run. The new language will necessarily require a re-interpretation of the meaning of a clear and unequivocal denial. Claimants' counsel will undoubtedly advocate for a broad, purposive approach to the interpretation of the revised section.

Finally, we expect that claimants will raise the spectre of bad faith if all the reasons for the denial of a claim are not disclosed. At a minimum, we expect that counsel will rely heavily on s.38(11)2 for the deemed approval of treatment plans in situations of non-compliance with s.38(8).

(c) Benefit Statements

In September 2010, the new *SABS* required insurers to provide a bi-monthly benefit statements to claimants indicating the amount paid by the insurer on behalf of the claimant for medical, rehabilitation and attendant care benefits as well as the amount spent on insurer examinations. The statement also required that insurers inform the claimant of the amount of benefits still remaining. However, the statements generally do not breakdown payments by provider or service. Consequently, consumers were unable to determine whether the payments made on their behalf were legitimate. Therefore, with the introduction of s.50(3), FSCO now has the authority to stipulate additional information that insurers must provide in bi-monthly benefit statements to claimants. The new provision anticipates that the Superintendent will, in the future, provide insurers with a standard format of the benefit statement form.

(d) Changes to Guidelines

Sections 15 and 16 of the *SABS* list the reasonable and necessary medical and rehabilitation expenses that the insurer is liable to pay, as well as the exemptions to the list. Amendments to sections 15(2)(b) and 16(4)(a) provide FSCO with the authority to stipulate by Guideline the maximum payable by insurers for goods as well as services. A revised Cost of Goods Guideline was issued by FSCO on May 29, 2013. The accompanying Bulletin (A-2/13) also released a number of revised claim forms, including the OCF-1. Expenses described in section 15(1)(g) and 16(3)(k) (transportation for the insured person to and from treatment sessions, counselling, and training sessions, including transportation for an aide or attendant) continue to be subject to the Transportation Expense Guideline.

O.Reg 15/13: *Unfair or Deceptive Acts or Practices*

Section 3 of the *Unfair or Deceptive Acts or Practices* outlines what constitutes unfair or deceptive acts by or on behalf of persons who submit a claim form. Ontario Regulation 15/13 has amended section 3(2) in a manner that makes it an unfair or deceptive act to request, require or permit an accident benefit claimant to sign an incomplete claim form.

However, section 3(4) makes it clear that section 3 does not apply to lawyers or paralegals "with respect to activities that constitute practicing law or providing legal services." As a result, lawyers and paralegals can request, require or permit their client to sign an incomplete claim form if they can show that they did so in the course of providing legal services or while engaging in activities that constitute practicing law. If the insurer suspects foul play, the recourse is to lodge a complaint with the Law Society of Upper Canada.

Pursuant to the new section 3(4), a failure to disclose a conflict of interest to a person who claims statutory accident benefits or to an insurer, as required under the *SABS*, specifically applies to lawyers and paralegals. Therefore, a conflict of interest could potentially exist where the lawyer or paralegal has a referral relationship with a treatment facility, or vice versa. However, if a lawyer is an owner of a clinic and not acting in a legal capacity, then any business practice that is in contravention of the *Insurance Act* would be subject to regulatory action by FSCO.

O. Reg 16/13: *Disputes Between Insurers*

O.Reg 16/13, amending O.Reg 283/95, recognizes that insurers should have the ability to examine a claimant under oath where it is necessary to determine priority for coverage, without prejudice to the right for an examination under oath with respect to entitlement to benefits. O.Reg 14/13 also amends the *SABS* by adding a new subsection (9) to s.33 which states:

> Clause (2)(a) shall not be interpreted as prohibiting an additional examination of the applicant under oath, under Ontario Regulation 283/95 (Disputes Between Insurers) made under the Act, at the insurer's request that is conducted for the purpose of determining who is liable under section 268 of the Act to pay statutory accident benefits in respect of the accident.

The amendments recognize the insurer's need to act diligently during the 90-day notice period yet not forego its "one kick at the can" examination under oath. The new provisions should assist insurers by allowing them to conduct a priority dispute examination without sacrificing their right under s.33 to conduct an additional examination under oath in respect of matters relating to entitlement to accident benefits or other issues.

The examination for the purpose of determining priority is available only to the first insurer to receive a completed application for accident benefits. The examination cannot be conducted for any other purpose and the applicant's attendance is mandatory (although neither O.Reg 283/95 nor the *SABS* reference any consequences if the applicant refuses or fails to attend).

It is not clear whether the insurer must have already taken steps under O.Reg 283/95 to dispute priority before notice of the examination under oath is provided to the applicant. Certainly, in some cases, the insurer may wish to complete an examination under oath with respect to priority as soon as possible and before formal steps are taken to dispute priority. Given the reasonableness of this strategy, we interpret the amendment as allowing an examination under oath before a notice of dispute has been provided.

Furthermore, unlike the *SABS,* O.Reg 283/95 is not part of the contract of insurance. Therefore, any obligations imposed upon the applicant may not be binding. The more prudent strategy may be to request the priority examination under oath pursuant to s.33 of the *SABS* and, if the claimant later refuses to attend an additional examination under oath in relation to other matters, the insurer may rely on s.33(9).

THE LAST WORD

While FSCO may not have direct regulatory authority on providers, as discussed above, it does indirectly control their actions when it comes to invoicing payment. Since FSCO does directly authorize what insurers can and cannot do, providers are essentially forced to accept the rules

under which insurers operate. Failing to do so would result in non-payment with little recourse for the provider.

However, FSCO's regulatory authority over providers will soon be changing. Sections 288.1 to 288.7 of the *Insurance Act* were recently enacted and provide for a licensing scheme for service providers and the payments from insurers to providers.[1] Schedule 8 of the amending legislation can be summarized as follows:

New Section in *Insurance Act*	**General provisions**
268.3	Guidelines incorporated by reference into *SABS* are now binding
288.1	Defines listed expenses as amounts payable for assessments and examinations, as well as goods and services that include benefits to be prescribed
288.2	Insurer cannot make payments for listed expenses to anyone that does not hold a service providers license
288.3	Establishes that there will be a registry of service providers
288.4	Holder a license is eligible to paid directly by insurer; establishes that issuance of license is subject to conditions
288.5	Application process for licensing
288.6	License may be revoked in listed circumstances
288.7	Application for license can also be refused in listed circumstances

These amendments will compel providers who deal with auto accidents to become licensed and regulated by FSCO in order to continue being providers for an insured. The implementation and effectiveness of this regulatory scheme remains to be seen. These amendments were created due to the recommendations provided by the 2012 report of the Anti-Fraud Task Force.[2] The amendments were passed into law but have not yet been proclaimed. They will come into force on a day to be named by proclamation, so it is currently unknown when they will take effect.

[1] *An Act to implement Budget measures and to enact and amend various Acts*, 2013, c.2, sch 8.
[2] Canada: Ontario Automobile Insurance Anti-Fraud Task Force, *Final Report of the Steering Committee* (November 2012), online: (http://www.fin.gov.on.ca/en/autoinsurance/final-report.pdf).