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INSURANCE LAW BULLETIN

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FSCO CLARIFIES DEFINITION OF "MEDICAL REASON"

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In *Augustin v. Unifund Assurance Company* (November 13, 2013, FSCO A12-000452), Arbitrator Susan Sapin clarified what would be considered a "medical reason" to deny a treatment plan submitted under s.38 of the Statutory Accident Benefits Schedule (SABS) if the insurer believed the claimant belonged within the Minor Injury Guideline (MIG) and request an examination under s.44.

Ms. Augustin submitted an OCF-18 to Unifund proposing treatment in the amount of $2,934.90. Her practitioner indicated on the treatment plan that Ms. Augustin's injuries fell outside the MIG. Unifund provided the applicant with an Explanation of Benefits which 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 impairment is predominantly a minor injury as described in the Minor Injury Guideline. Please see the Notice of Examination for further details."

Ms. Augustin refused to attend the assessment. Unifund responded by denying her claim for treatment on the basis that she was non-compliant with s.44. Accordingly, Unifund relied on s.55.2[1] of the SABS to argue a motion before FSCO that Ms. Augustin was precluded from mediating the disputed treatment plan because the failed to attend an insurer's assessment.

Ms. Augustin took the position that the insurer could not invoke s.55.2 unless it provided her with a notice under s.44(5) that was in accordance with the Regulation. The claimant maintained that Unifund's notice did not comply with s.44(5) because the notice failed to provide

[1] S. 55(2): An insured person shall not commence a mediation proceeding under section 280 of the Act if any of the following circumstances exist: 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.

her with a "medical" reason for refusing to pay for the treatment plan, contrary to s.38(8) of the SABS.
Arbitrator Sapin agreed that Unifund's notices did not comply with either s.38 or s.44 of the SABS. Regarding the notice requirements under s.38(9)[2] she found that Unifund's response did not comply with that section because it did not state that Unifund *believed* the MIG applied. Stating a belief that the MIG applied, however, was not in and of itself a sufficient reason for refusing to pay a claim for treatment. The second requirement was that the belief had to be explained and supported by some medical or other reason. Arbitrator Sapin felt that this was reasonable given that the insured's treatment provider was required to provide a factually based medical opinion to support a claim for treatment outside of the MIG.

Arbitrator Sapin gave the opinion that insurers must communicate the following information when it chooses to refuse a treatment plan because it believes the MIG applies:

1. That it has reviewed the Treatment and Assessment Plan and any medical documentation provided;

2. That it has compared it to the criteria in the MIG;

3. That it has determined either that there is insufficient compelling evidence of pre-existing injuries or conditions, or insufficient medical documentation to persuade it that the accident injuries fall outside of the MIG; and

4. That it believes that that 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).

According to Arbitrator Sapin, a response that included the above would meet the insurer's obligation to provide "medical reasons" as required by s.38(8). Arbitrator Sapin held that the "medical and other reasons for the examination" under s.44(5) should contain substantially similar information.

COMMENTARY

Arbitrator Sapin provided useful clarification with respect to the wording requirements of a notice under sections 38(8) and 44 of the SABS. Unfortunately, the clarification may serve to invalidate a large number of notices that have already been sent to claimants by insurers prior to the release of Arbitrator Sapin's decision. Therefore, it would be wise for insurers to implement the suggestions made by Arbitrator Sapin when dealing with claims for treatment that insurers believe fall within the MIG. The following should be included in any denial under s.38 or request for an insurer's assessment under s.44:

> The [insurer] has reviewed the Minor Injuries Guideline (MIG) and the medical opinion of [treating health practitioner] that [your injuries are not predominantly minor] or [that your injuries are predominantly minor but that you do not come with the MIG because you

[2] 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 insured person.

> have a pre-existing medical condition that prevents you from achieving maximal recovery if you are subjected to the MIG]. However, when compared to the criteria set out in the MIG, and the medical documentation provided, it is the conclusion of the insurer that [treating health practitioner] has not provided compelling evidence that your injuries are outside the MIG, or that the treatment claimed is reasonable or necessary.

We note, with interest, that a similar matter was argued before Arbitrator Maggy Murray on May 9, 2013. She held in *Quinones v. Unifund Assurance Co.* (FSCO A12-000866) that an insurer's explanation that it required a "second opinion" to determine the claimant's entitlement to a benefit constituted a "medical reason". It therefore seems open to argument that the requirement for an *initial* opinion regarding entitlement, as was the insurer's situation in *Augustin*, also constitutes a "medical reason".