Licence Appeal Tribunal File Number: 22-000813/AABS

In the matter of an Application for Dispute Resolution pursuant to subsection 280(2) of the *Insurance Act,* RSO 1990, c I.8., in relation to statutory accident benefits.

Between:

Hildegard Radebach
(By her litigation guardians, Christine Radebach and Shirley Radebach)
Applicant

and

Intact Insurance Company
Respondent

MOTION ORDER

ADJUDICATOR:	**Ludmilla Jarda**
APPEARANCES:	
For the Applicant:	Roger Foisy, Counsel Harpreet Sidhu, Counsel Daniel Berman, Counsel Rusald Laloshi, Paralegal
For the Respondent:	Leah Dick, Counsel
Motion heard by Written Submissions:	**August 9, 2022**

BACKGROUND

[1] The applicant was injured in an automobile accident on **May 19, 2017** and sought benefits pursuant to the Statutory Accident Benefits Schedule – Effective September 1, 2010 ("Schedule").

[2] The applicant was denied certain benefits and submitted an application to the Licence Appeal Tribunal - Automobile Accident Benefits Service ("Tribunal").

[3] A case conference took place on **May 11, 2022**. The issues in dispute are whether the applicant is entitled to medical and rehabilitation benefits, an award, and interest. A written hearing was scheduled for February 10, 2023.

[4] At the case conference, the respondent raised a preliminary issue that the applicant was barred from proceeding with her application because she failed to attend the respondent's section 44 insurer examination ("IE") requests.

MOTION

[5] On **June 10, 2022**, the respondent filed a Notice of Motion seeking the following relief:

a. An order that the applicant is procedurally barred from proceeding with the subject application before the Tribunal pursuant to section 55 of the Schedule;

b. An order vacating the written hearing scheduled for February 10, 2023; and

c. An order staying the application unless or until the applicant complies with section 44 of the Schedule with respect to the issues in dispute.

[6] The applicant sought an order dismissing the respondent's motion and a finding of fact that the respondent failed to provide a notice that complied with section 38(8) and 44(5) of the Schedule.

RESULT

[1] The respondent's motion is denied.

[2] The respondent's January 22, 2020, March 23, 2020, and March 31, 2020 denial letters and March 31, 2020, April 6, 2020, June 4, 2020, and June 22, 2020 notices of examination did not comply with the content requirements noted within sections 38(8) and 44(5) of the Schedule.

[3] The applicant is not precluded from proceeding with her application with respect to her entitlement to medical and rehabilitation benefits pursuant to section 55 of the Schedule.

[4] As explicitly stated by the respondent in their reply submissions dated June 30, 2022, the reasonableness and necessity of the proposed IE assessments are not issues to be decided on this motion. Accordingly, I will defer this to the hearing adjudicator.

[5] In the circumstances, there is no need to stay the application or to vacate the written hearing. The latter shall proceed as scheduled.

ANALYSIS

Did the respondent's denial letters and notices of examination comply with their obligations under section 38(8) and 44(5) of the Schedule?

[6] With respect to the January 22, 2020, March 23, 2020, and March 31, 2020 denial letters and March 31, 2020, April 6, 2020, June 4, 2020, and June 22, 2020 notices of examination, I find that the respondent did not comply with their obligations under sections 38(8) and 44(5) of the Schedule as they failed to include medical reasons and all of the other reasons why they considered the treatment and assessment plans (OCF-18s) not to be reasonable and necessary. As a result, the denial letters and notices did not obligate the applicant to attend the proposed IEs.

[7] Pursuant to section 38(8) of the Schedule, when an insurer receives an OCF-18, within 10 business days, the insurer shall give the insured person a notice that identifies the goods, services, assessments and examinations described in the OCF-18 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, services, assessments and examination, or the proposed costs of them, not to be reasonable and necessary.

[8] Moreover, if the insurer requires an examination under section 44 of the Schedule for the purpose of assisting in determining whether the insured person is or continues to be entitled to a benefit under the Schedule for which an application is made, but not more often than is reasonably necessary, the insurer is required, among other things, to set out the medical and any other reasons for the examination pursuant to section 44(5) of the Schedule.

[9] In January 2020, the applicant submitted an OCF-18 dated December 17, 2019 for a hearing assessment in the amount of $1,950.00.

[10] On January 9, 2020, the applicant submitted an OCF-18 dated December 18, 2019 for a neuro-optometric evaluation in the amount of $2,200.00.

[11] On January 22, 2020, the respondent did not agree to pay for the hearing assessment and the neuro-optometric evaluation pursuant to section 38(8) of the Schedule and indicated the following reasons:

- The goods and services recommended by these OCF-18s may be covered through OHIP with the proper referral.
- Further, they did not have medical documentation indicating that the issues are a direct result of the accident.

[12] On February 4, 2020 and February 10, 2020, the applicant's case manager provided supplemental medical information with respect to the OCF-18s and relied on previous medical evidence.

[13] On March 23, 2020, the respondent reiterated their denial with respect to the hearing assessment and provided the following reasons:

- To determine if the issues the insured is having with her hearing aids, is a direct result of the accident. Causation.

The respondent advised that pursuant to section 38(10) and 44 of the Schedule, arrangements had been made for the applicant to participate in an independent medical assessment to determine whether the OCF-18 is reasonable and necessary, and as a result of the accident. No notice of examination was provided at that time.

[14] On March 31, 2022, the respondent reiterated their denial with respect to the neuro-optometric evaluation and provided the following reasons:

- To determine if the insured is having [*sic*], is a direct result of the accident.

The respondent advised that pursuant to section 38(10) and 44 of the Schedule, arrangements had been made for the applicant to participate in an independent medical assessment to determine whether the OCF-18 is reasonable and necessary, and as a result of the accident.

[15] A notice of examination was provided at that time. According to the notice, an assessment was scheduled with Dr. Calvin William Breslin, an ophthalmologist, for May 19, 2020. Under "Reason and Description of the Examination", the

respondent indicated as follows:

- OCF-18 dated December 18th in the amount of $2200.00
- To determine if the insured is having [*sic*], is a direct result of the accident.

[16] On April 6, 2020, a notice of examination was provided regarding the hearing assessment. According to the notice, an assessment was scheduled with Dr. Guillermo Castillo, an ear, nose, and throat specialist, for June 1, 2020. Under "Reason and Description of the Examination", the respondent indicated as follows:

- To determine if the issues the insured is having with her hearing and aids, is a direct result of the accident. Causation.
- We request an in person examination.

[17] On April 11, 2020, the applicant objected to the proposed IEs based on various reasons. Among those reasons, the applicant took the position that the notices did not comply with the Schedule and requested revised notices.

[18] On April 15, 2020, the respondent indicated the following regarding the reason for the assessments:

- With [*sic*] reason for the assessments, given that Ms. Radebch has [*sic*] both hearing and sight issues prior to this loss, and given her age, as you pointed out, it is a reasonable request to determine causation from professionals, as opposed to an OT. Further we have no qualified medical evidence to support that her symptoms are directly related to the accident.

[19] The assessments were rescheduled, and on June 4, 2020 and June 22, 2020, two more notices of examination were issued. The first notice was for an assessment with Dr. Gregory Belchtz, an otolaryngologist, on July 13, 2020, and the second notice was for an assessment with Dr. Breslin on August 4, 2020. The notices were virtually identical to the previous notices.

[20] To date, the applicant has not attended the respondent's proposed IEs.

[21] The respondent submitted that the purpose of section 44 assessments is to allow an insurer to obtain an independent medical opinion on the insured person's accident-related impairments so that they may fairly and properly assess claims

made by the insured person. The respondent relied on section 44(9) of the Schedule and indicated that the insured person is required to cooperate and submit to all reasonable examinations requested by the examiner. Moreover, the respondent took the position that the notices of examination provided sufficient medical reasons to inform the applicant why the examinations were required.

[22] The applicant submitted that the notices of examination did not comply with section 44 of the Schedule. She indicated that the notices provided by the respondent did not offer any rationale for why they were arranging the section 44 IEs. The respondent did not provide medical and any other reasons for arranging the section 44 assessments as required by section 44(5) of the Schedule despite requests.

[23] For the following reasons, I agree with the applicant.

[24] As indicated in *16-003316/AABS v. Peel Mutual Insurance Company*, 2018 CanLII 39373 (ON LAT), upon denial of an OCF-18, an IE is not mandatory, and it is at the insurer's discretion. However, the insurer is required to outline the medical and all other reasons for denying the OCF-18. Indeed, as noted at paragraph 21:

> [A]n insurer's "medical reasons" for denying a plan should engage the specific details about the insured's condition forming the basis for the insurer's decision. They should also be adequate enough to allow an unsophisticated person to understand them and make an informed decision in response. Those entitled to accident benefits should not have to wonder why they are denied treatment. Nor should they have to incur the temporal, emotional, and financial costs associated in engaging the Tribunal in order to obtain the treatment they should have received long before. If s. 38(8) is to achieve its purpose, it must require insurer to accompany any denial of benefits with meaningful and accurate reasons based on an insured's medical condition as described in the file at hand.

[25] Moreover, in *M.B. v. Aviva Insurance Canada*, 2017 CanLII 87160 (ON LAT), the Tribunal set out the requirements for "medical and any other reasons" as follows at paragraph 26:

> In my view, an insurer satisfies its obligation to provide its "medical and any other reasons," whether under s. 44(5)(a) or elsewhere, by explaining its decision with reference to the insured's medical condition and any other applicable rationale. That explanation will turn on the unique facts at hand. Therefore, it would be unwise to attempt to outline a

> comprehensive approach to doing so. Nevertheless, an insurer's "medical and any other reasons" should, at the very least, include specific details about the insured's condition forming the basis for the insurer's decision or, alternatively, identify information about the insured's condition that the insurer does not have but requires. Additionally, an insurer should also refer to the specific benefit or determination at issue, along with any section of the *Schedule* upon which it relies. Ultimately, an insurer's "medical and any other reasons" should be clear and sufficient enough to allow an unsophisticated person to make an informed decision to either accept or dispute the decision at issue. Only then will the explanation serve the *Schedule's* consumer protection goal.

[26] Also, in *Applicant v. Aviva*, 2018 CanLII 112135 (ON LAT), the respondent's explanation of benefits was insufficient, and the adjudicator noted as follows at paragraph 29:

> It gave no details with respect to why the proposed treatment was not consistent with the diagnosis. It provided no specific details about the insured's condition that formed the basis for its decision. Not only that, but when the respondent was given a chance to remedy the lack of particularity in response to the applicant's lawyers' inquiry, it responded by providing no further information, but instead simply telling her to comply.

[27] The reasons given by the respondent on January 22, 2020 for denying the OCF-18s as well as the reasons given in the March 23, 2020 and March 31, 2020 denial letters and the March 31, 2020, April 6, 2020, June 4, 2020, and June 22, 2020 notices of examination did not include specific details about the applicant's condition nor did they identify information about the applicant's condition that the respondent did not have but required. I find that simply stating that there's no medical documentation indicating that the issue is a direct result of the accident and claiming that causation is an issue without making any reference to the applicant's condition and/or medical information is insufficient to meet the respondent's obligations under the Schedule. Therefore, the respondent's denial letters and notices are and continue to be deficient, despite having the opportunity to correct the deficiencies, and as such, the applicant is not obligated to attend the proposed IEs.

Does the applicant's failure to attend at the proposed IEs bar this proceeding pursuant to section 55 of the Schedule?

[28] The applicant is not barred from proceeding with her application with respect to the OCF-18s pursuant to section 55 of the Schedule.

[29] Pursuant to section 55(1)2 of the Schedule, an insured person shall not apply to the Tribunal under section 280(2) of the *Insurance Act*, R.S.O. 1990, c. I.8 if the insurer has provided the insured person with notice in accordance with the Schedule that it requires an examination under section 44, but the insured person has not complied with that section.

[30] Pursuant to section 55(2), the Tribunal may permit an insured person to apply despite the above provision.

[31] The applicant submitted that the respondent's detrimental failure to comply with their obligations under section 38(8) and 44(5) of the Schedule prohibited them from relying on Section 55(1) to bar the applicant's application from proceeding.

[32] The respondent submitted that failure to attend the section 44 assessments bars the applicant from commencing litigation pursuant to section 55(1)2 of the Schedule. Further, it would be unfair to require the respondent to proceed to a hearing without section 44 IE reports. Procedural fairness requires that a party have an opportunity to be heard and that it be able to respond to the position taken against it.[1]

[33] Alternatively, the respondent submitted that the Tribunal should stay the proceedings in order to allow the respondent to conduct IEs and relied on *Applicant v. Security National Insurance Company*, 2019 CanLII 101545 (ON LAT). In that case, given that the proposed catastrophic IE was found to be reasonable and necessary, the Tribunal stayed the application to allow time for the applicant to attend the assessment and for the respondent to obtain the catastrophic IE report. However, I do not find this decision helpful to the respondent. This case dealt with a catastrophic impairment designation as opposed to the applicant's entitlement to a medical benefit. Further, the adjudicator permitted the stay in part because they found that the catastrophic IE was reasonable and necessary. In contrast, I am not in a position to comment on the reasonableness and necessity of the proposed IEs as the respondent explicitly stated in their reply submissions dated June 30, 2022, that these are not issues to be decided on this motion. Accordingly, I will defer this to the hearing adjudicator.

[34] I agree with the applicant. Given that the denial letters and notices were and continue to be non-compliant with the Schedule, the applicant should not be precluded from proceeding with her application. It would be unfair to the applicant to stay her application when the respondent has yet to meet their statutory

[1] *Certas Direct Insurance Company v. Gonsalves*, 2011 ONSC 3986 at para 8

obligations under section 44(5) of the Schedule.

CONCLUSION

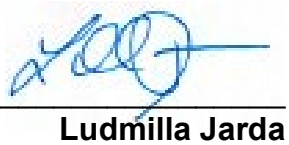
[35] The respondent's motion is denied.

[36] The written hearing scheduled for February 10, 2023 shall proceed as scheduled.

[37] **Except for the provisions contained in this Motion Order all previous orders made by the Tribunal remain in full force and effect**.

[38] If the parties resolve the issue(s) in dispute prior to the hearing**, the applicant** shall immediately advise the Tribunal in writing.

Released: August 25, 2022



Ludmilla Jarda
Adjudicator