ALIEN POWER OF THE GREEN LANTERN RING

Disability Certificates, "Medical and other Reasons" and In Between

By

David Raposo
Dutton Brock
November 17, 2017

Since the LAT's inception on April 1, 2016, it has been busy issuing decisions on a variety of issues but this paper will focus on some of the LAT's decisions interpreting procedural provisions and in particular some of the decisions surrounding "medical and all other reasons" as well as Disability Certificates (OCF-3's).

MEDICAL AND OTHER REASONS

The LAT started off strong in interpreting "medical and all other reasons" as outlined in Section 38(8) of the SABS. More specifically in *J.W. v. The Co-Operators General Insurance Company* (Tribunal No. 16-000248/AABS) Adjudicator Richards seemed to loosen the requirement for medical reasons by focusing on procedural fairness and an

insurer having an opportunity to obtain and gather its own medical documentation. He concluded that the medical and other reasons are the reasons that are unique to each case and that justify the insurer's request for further investigation and that a request to determine the timelines for the Applicant's recovery and future prognosis in relation to his injuries were in fact valid "medical and any other reasons". That case was discussed in detail at the Dutton Brock's seminar in 2016 and since that time there have been a variety of other decisions interpreting this provision.

In *S.C. v. Aviva* (2017 CanLII 70684) the insured person refused to attend a variety of IE's on the basis that the insurer allegedly did not provide a medical reason. The medical reason provided in the Notices in question was "upon review of the minor injury guideline and the treating practitioner's medical opinion, we have concluded the health practitioner has not provided compelling evidence the impairment sustained is not predominantly a minor injury". Adjudicator Maedel concluded "I find that the Notices are clear that the treating health practitioners opinion and the MIG have been reviewed and compared, and the practitioner has not provided compelling evidence that the Applicant has not sustained a minor injury. This follows the minimum requirements set out by Arbitrator Sapin in *Augustin"*. The Applicant was therefore precluded from proceeding with the claim for various treatment plans.

In *Applicant v. Certas* (2017 CanLII 70683) the parties managed to resolve all issues except for two treatment plans including a proposed psychological assessment with Dr. Pilowsky. In refusing to attend the IE, the Applicant raised a variety of concerns and reasons one of which was that the insurer failed to issue a proper Notice in accordance with Section 44 for the IE. The Notice of Examination in question stated that its purpose

was to assess whether the OCF-18 submitted by Dr. Pilowsky proposing a psychological assessment was reasonable. The insurer did not provide any medical reason for the examination and as such, Adjudicator Go found the Section 44 Notice to be non-compliant. The insured person was entitled to proceed with the hearing for determination as to whether the proposed psychological assessment was reasonable and necessary.

Adjudicator Go reached a different conclusion with respect to "medical and other reasons" in *Applicant v. Aviva* ((2017) CanLII 69450). Similar to other cases, the insured person raised a variety of arguments as to why it did not have to participate in the IE, one of which being deficient notice. In this case, the Notice stated "upon review of the minor injury guideline and the treating practitioner's medical opinion, we have concluded the health practitioner has not provided compelling evidence the impairment sustained is not predominantly a minor injury". The Adjudicator (and both parties) adopted the test in *L.S. v. Certas* when Adjudicator Flude described the following requirements to satisfy the obligation to provide "medical and other reasons":

> "Where there is a dispute whether the MIG applies, as in the current matter, the insurance company must state that it has reviewed the MIG and the treating health practitioner's opinion and concluded that, in the view of the insurance company, they do not provide compelling evidence that the injuries fall outside the MIG or that the treatment is reasonable or necessary".

Adjudicator Go therefore concluded that the Notice was in fact proper and met the requirements of both the schedule and the tests set out by Adjudicator Flude as the insurer did state in a letter that it has reviewed the MIG and the treating health practitioner's opinion in concluding that the applicant has not provided compelling

evidence that the injuries fall outside of the MIG or that the treatment is reasonable or necessary. As an aside, Adjudicator Go also found as a fact that other relevant factors included whether there was a reasonable nexus between the type of Examination and the claimed impairments, whether there was evidence that the IE was timed to bolster the insurer's case before the LAT, the number of IE's requested and whether proceeding without the IE would be prejudicial to the insurer.

In *I.K. v. Primmum Insurance* (Tribunal No. 16-001652/AABS) Adjudicator Marzinotto also addressed the issue of medical and other reasons. In requesting an IE, Primmum indicated that based on the medical information it had it did not have sufficient medical information to assist them in making a determination on eligibility for non-earner benefits. The Notice provided the details of the IE's and further indicated if the Applicant could not attend he was to contact them to make other arrangements. The Applicant's counsel wrote to the insurer and took the position that non-earner benefits has to be paid up to date prior to arranging IE's and the Adjudicator confirmed that was not necessarily the case. A few months elapsed and the insurer received a variety of treatment plans and again attempted to arrange Insurer Examinations and the Applicant again refused and counsel for the Applicant wrote to the insurer and stated "please send us proper Notice with respect to the proposed Assessments along with the questions to be posed to the Assessor. Once we are in receipt of same, along with all other information required by the SABS, we may be contacted for scheduling purposes". The Adjudicator found the Applicant's demands in that letter including the demand for questions posed to the Assessor were unreasonable, nor was that a requirement under the SABS. Additionally, the Applicant did not indicate why the previous Notices were improper or

why they may have been improper. The Adjudicator concluded the Applicant was trying to "dictate an adjusting process contrary to the Schedule" and the Applicant was deemed to be in non-compliance under Section 55.

DISABILITY CERTIFICATES

Section 36 of the SABS is clear in stating that when applying for a specified benefit, "an Applicant for a specified benefit shall submit a completed Disability Certificate with his or her Application under Section 32". Subsection (3) states: "an Applicant who fails to submit a completed Disability Certificate is not entitled to a specified benefit for any period before the completed Disability Certificate is submitted".

In the decision of *Walker* v. *The Co-Operators General Insurance Company* (Tribunal No. 17-000388\AABS), the Applicant was involved in an accident on September 17, 2013. The initial Application package indicated the Applicant may qualify for an income replacement benefit and Co-Op had requested an OCF-3 Disability Certificate on a variety of occasions in order to determine entitlement. The Applicant ultimately submitted two Disability Certificates dated October 10, 2013 and a second one dated February 13, 2017. The first Disability Certificate dated October 10, 2013 did not confirm entitlement to Income Replacement Benefits but indicated that the test for IRB was "N/A". The second Disability Certificate, submitted approximately 3.5 years later on February 13, 2017 did confirm entitlement to the Income Replacement Benefit. Co-Op took the position that because the Applicant failed to submit a "positive" Disability Certificate confirming entitlement within 104 weeks following the accident that he was precluded from proceeding with the said Claim. Adjudicator Paluch concluded that the

word “completed” in Section 36 cannot be equated to mean “positive”. In other words, he concluded that all that is required is the submission of a completed Disability Certificate. He noted that a document can be completed if all the fields are filled in and even if it does not confirm entitlement to a particular benefit that does not render the Certificate incomplete. He noted that the doctor who issued the first Disability Certificate chose one of the three options available to him being “not applicable” and therefore he completed the Disability Certificate properly.

The Adjudicator found the insurer’s position “very restrictive” and too much weight being placed on one question. He stated that the insurer’s position “leaves the Applicant’s health practitioner complete power to effectively negate a claim simply by means of checking the “No” box, or as in this case, the “N/A” box”. He noted this type of restraining approach is not in keeping with the overall objectives of the *Insurance Act* which emphasizes consumer protection and that Section 36 must be interpreted in a “fair, liberal and purposive” manner to achieve the objectives of protecting an insured’s rights to Statutory Accident Benefits”. Adjudicator Paluch also noted the Disability Certificate is not the sole factor to consider when determining whether a Claimant meets the disability test for an Income Replacement Benefit although it is a “integral part” of the analysis. He states that paragraph 30:

> “In summary, I find the state of the law to be that a “completed Disability Certificate” need not be a “positive Certificate” or a Certificate that has to absolutely confirm entitlement to IRB’s. It merely has to be a “completed Disability Certificate” that conforms to the formalities required by Section 67 of the Schedule and the completion instructions on the actual OCF-3 form”.

Adjudicator Paluch also made a distinction between applying and qualifying for IRB and notes there is no requirement in the SABS which specifically dictates that in order to receive an IRB an insured person must apply within a 104 weeks of the accident. He notes that the schedule only dictates that the Claimant suffer a substantial inability to perform the essential tasks of that employment within 104 weeks. However, in the end the Adjudicator went on to provide an analysis with respect to entitlement and still found that in accordance with Section 5 of the SABS to be eligible for an IRB an insured person must as a result of and within a 104 weeks after the accident suffer a substantial inability to perform the essential tasks of their pre-accident employment. He found as a fact that the medical documentation relied upon was all commissioned post 104 weeks, including the second Disability Certificate which confirmed entitlement, and as there were no medical reports produced within 104 weeks of the accident to positively answer the specific question as to whether he met the test he was precluded from receiving Income Replacement Benefit and the Application was dismissed.

The issue of Disability Certificates was also addressed in *O.A. v. TD General Insurance* (2017 CanLII 69447). In this decision, Adjudicator Nielson heard a preliminary issue as to whether the Applicant was precluded from bringing her Claim for IRB's for failing to submit a Disability Certificate providing substantive support for entitlement to IRB's. In this decision, the initial Disability Certificate indicated the insured person did not meet the IRB test but was received within 104 weeks. The insurer took the position that in accordance with Section 36, none of the three Disability Certificates submitted by the Applicant were considered "completed" Disability Certificates because they did not

specifically confirm entitlement to the Income Replacement Benefit. The Adjudicator did not agree and the following paragraphs are of interest:

> "I find that when Section 32 is read together with Section 36, that a "completed Disability Certificate" referred to in Section 36(3) means a Disability Certificate that contains enough information to allow an insurer to determine whether an insured person is entitled to a specified benefit, such as IRB's or at least allows an insurer to be able to identify whether, pursuant to Section 36(4)(c) of the Schedule, it needs to request more information from the insured person pursuant to Section 33(1) or (2) of the Schedule or from a medical practitioner by way of an Insurer's Examination pursuant to Section 44 of the Schedule.
>
> While I do not know what other information the Applicant may rely on in support of her Claim for IRB's, I am not prepared to prevent her from having the opportunity to present evidence on the issue just because her initial Disability Certificate indicated she was not entitled to IRB's as of September 18, 2014. Particularly when there is no requirement that the Applicant's inability to engage in the essential tasks of her pre-accident employment is to occur as of the time of the accident. Rather, the inability may occur at any time within 104 weeks of the accident for the Applicant to qualify.
>
> The lack of clarity from the Applicant's doctor should not act as a barrier to this matter proceeding to a Hearing at the Tribunal. If the Disability Certificates were not clear as to whether the Applicant met the test for entitlement, the Respondent had a number of options and obligations. Its failure to request an Insurer's Examination or to advise the Applicant in a clear and timely manner as to what information was deficient should not now act as

> a barrier to the Applicant in presenting her Claim".

Adjudicator Nielson seems to almost place a reverse onus on the insurer to gather information in determining whether or not the insured person meets the IRB test. It is not clear whether this decision is under reconsideration or Appeal. Nevertheless, what is clear is that based on the current state of the law:

(1) an insured person is required to submit a completed Disability Certificate in support of their Claim for specified benefits;

(2) a completed Disability Certificate does have to be submitted within 104 weeks of the accident; and

(3) the Disability Certificate does not necessarily have to support entitlement to the specified benefit. It only has to be completed.

At the end of the day, it appears that the LAT will make all efforts to ensure that the parties have an opportunity to be heard and Adjudicators are loathe to preclude an insured person or insurer from advancing a Claim or a Defence based on technical arguments.