FSRA is actively reviewing all FSCO regulatory direction, including but not limited to forms, guidelines and FAQs.

Until FSRA issues new regulatory direction, all existing regulatory direction remains in force.

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Insurer Rights and Responsibilities to Challenge Questionable or Abusive Claims

Bulletin

No. A-02/11
– Auto
Property & Casualty

To the attention of all insurance companies licensed to transact automobile insurance in Ontario and all health care providers

With this Bulletin, the Financial Services Commission of Ontario (FSCO) is reminding insurers of their rights and responsibilities under the Statutory Accident Benefits Schedule – Effective September 1, 2010 (SABS) to challenge questionable or abusive claims.

FSCO is monitoring on an ongoing basis the interpretation and application of the SABS and associated Guidelines by its stakeholders, with a view to identifying and responding to actions that are inconsistent with the recent auto reforms. FSCO recognizes that an overwhelming majority of stakeholders are fair and responsible participants in the auto insurance system. However, FSCO is also aware that a small group of service providers and representatives continue to abuse the system.

Insurers are expected to have and use policies and procedures that comply with best practices and legislative requirements when adjusting all claims. Consistent with the Insurance Bureau of Canada's Standards of Sound Marketplace Practice - March 6, 2006, FSCO expects "that claims are handled as expeditiously as possible and in accordance with any legal requirements, with fairness and transparency to the claimant."

All stakeholders in the auto insurance system should assume responsibility to ensure that auto insurance benefits are delivered effectively and efficiently, taking into account the need for balancing fair treatment of accident victims with affordability of insurance coverage for drivers.

Ontario's auto insurance legislation, including the recent auto insurance reforms that became effective on September 1, 2010, includes measures to facilitate the expeditious handling of accident benefit claims by insurers while at the same time assisting in the management of abusive claims practices.

Those measures include the following:

Scheduled Online Service Disruption Notice

Please consult our **outage schedule** for more details.

The Minor Injury Guideline (MIG)

The SABS and the MIG are intended to encourage and promote the broadest use of the Guideline, recognizing that the majority of people injured in car accidents in Ontario sustain minor injuries for which the goods and services provided under the MIG are appropriate.

"Minor injury" is defined in the SABS as one or more of a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury.

A person who sustains an impairment that is predominantly a minor injury is subject to the MIG. A person will not be excluded from the MIG unless he or she sustains serious injuries that do not meet the SABS definition of "minor injury," or in extremely limited instances where compelling evidence satisfactorily demonstrates that a pre-existing condition will prevent that person from achieving maximal recovery if he or she is limited to MIG treatment.

It appears that some providers are requesting approval for treatment of minor injuries on a Treatment and Assessment Plan (OCF-18) rather than providing pre-approved treatment under the MIG by submitting a Treatment Confirmation Form (OCF-23).

The auto reforms are still fairly new and not all providers are familiar with the minor injury definition and the MIG. In particular, not all providers are aware that the existence of other injuries and conditions will not necessarily bring a claimant outside the MIG if the predominant impairment falls under the minor injury definition. Insurers have a role in educating providers about the MIG so that future claims can be processed expeditiously. FSCO is aware that some insurers have been successfully using this approach.

In addition to a physical injury sustained in an accident, some insured persons may experience psycho-social issues such as depression, coping issues or anxiety. However, psycho-social issues do not necessarily require treatment of a claimant outside the MIG. It is appropriate and permitted by the SABS and the MIG for insurers to inform providers that psycho-social issues arising in connection with minor injuries can be addressed within the MIG, under the supplementary goods and services category, during the treatment phase. If an insurer considers it to be necessary to substantiate its position, it may require an insurer examination.

Multiple Treatment and Assessment Requests

It appears that a small number of providers engage in the practice of flooding insurers with multiple versions of similar or identical treatment and assessment plans (OCF-18s) in an apparent attempt to overwhelm adjusters. In many cases it appears that the objective is to cause adjusters to miss the approval timelines set out in the SABS.

This type of behaviour is clearly inappropriate. The recent auto insurance reforms have streamlined the process for reviewing OCF-18s. Insurers can exercise discretion over whether to make a determination on an OCF-18 with or without an insurer examination. Insurers may also reject an application on the basis that the same or a similar OCF-18 has already been reviewed and rejected. There is no obligation to undertake an insurer examination for each treatment or assessment request.

In addition, section 25 (1) 3 of the SABS provides that an insurer has no obligation to pay for review or

approval of an OCF-18, including any assessment or examination for that purpose, unless one or more of the proposed goods or services have been approved by the insurer or have been determined to be payable through the dispute resolution process.

Verifying Invoices and Expenses

In some instances it appears that insurers are not taking the necessary steps to confirm, or appear to have difficulty confirming, whether a covered expense for goods or services or expense has actually been incurred.

The SABS expressly provides that covered expenses are payable by an insurer only if they have been "incurred." The SABS further provides that a covered expense is not "incurred" unless:

- the claimant has actually received the goods or service to which the expense relates,
- the claimant has paid the expense, has promised to pay the expense or is otherwise legally obligated to pay the expense, and
- the person who provided the goods or services,
    - did so in the course of the employment, occupation or profession in which he or she would ordinarily have been engaged, but for the accident, or
    - sustained an economic loss as a result of providing the goods or services to the claimant.

It is incumbent upon insurers to ask for documentation and information as necessary to verify that a covered expense was actually incurred within the meaning of the SABS before paying an invoice, and it is reasonable for an insurer to inform a claimant or his or her provider that an invoice will not be paid until it can be verified that the expense was incurred.

Insurers may wish to inform claimants and their providers at the time an OCF-18 is approved that they may be asked to verify that invoiced expenses have actually been "incurred" within the meaning of the SABS at the time the invoices are submitted.

Third Party Billing

The SABS also specifies that although benefits, including expenses in respect of medical and rehabilitation goods and services, are generally to be paid directly to the claimant, insurers have the discretion under section 48 (2) (a) to arrange with service providers for direct payment. In doing so, an insurer is free to set out specific reasonable conditions under which would it agree to direct payment, including a process for verifying that expenses were "incurred."

Periodic Benefit Statements

The SABS requires insurers to provide their claimants with periodic statements of the amounts paid for medical, rehabilitation and attendant care benefits and the amounts remaining available. Insurers are

encouraged to take advantage of this opportunity by encouraging claimants to closely review their statements and report any instances of amounts paid out on their behalf for goods services not actually received, as such amounts may directly affect the claimants' entitlement to remaining coverage.

Examinations Under Oath

There is a duty for a claimant to provide all relevant information to an insurer regarding any application for accident benefits. When an insurer is unable to determine entitlement to accident benefits, insurers have the discretion under section 33 (2) to request a claimant to submit to an examination under oath. Insurers must adhere to all the provisions set out in this section, including: the limit of one examination in respect of each accident; the claimant's right to be represented; scheduling a time and location that is convenient for the claimant; and limiting the scope of the examination to matters that are relevant to the entitlement of benefits. If a claimant fails to comply, an insurer is not liable to pay a benefit during that period.

Philip Howell
Chief Executive Officer and
Superintendent of Financial Services

March 22, 2011