Providing Sufficient Medical and Other Reasons Under the Statutory Accident Benefits Schedule

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Every day accident benefits adjusters find themselves responding to claims for benefits, and every day they find themselves questioning whether the notice they provide with respect to those benefits will be deemed sufficient. The stakes are high, given that a finding of invalid notice can result in whatever benefit the notice sought to address being deemed payable, with interest and the ever present risk of a special award. Typically disputes with respect to notice stem from the requirement that an insurer provide medical and any other reasons for its decision. Thankfully, the case law has evolved to a state where there is now a clear standard as to what constitutes sufficient reasons, providing much needed guidance in what has traditionally been a murky area of law.

Requirement for Notice

The requirement that an insurer provide notice of its decisions to an insured person can be found almost everywhere in the Statutory Accident Benefits Schedule. Whether it be to deny a benefit, request that an insured person attend an insurer's examination assessment, or deny that an insured person is catastrophically impaired, the Schedule makes it clear that insurers have a duty to keep

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insured persons appraised of decisions made with respect to their claims.

A common feature of the notice provisions outlined above is that they all require an insurer to provide the "medical and any other reasons" for a denial. The Schedule does not elaborate further.

Review of the Case Law

There have been two important decisions issued by the Licence Appeal Tribunal regarding sufficiency of notice. In the first, M.B. v. Aviva Insurance Canada, 2017 CarswellOnt 20635, Executive Chair Lamoureux concluded that the following was the minimum required in order for reasons to be deemed sufficient:

"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."

In the reconsideration decision of T.F. v. Peel Mutual Insurance Company, 2018 CarswellOnt 7165, Executive Chair Lamoureux again weighed in on the

issue of sufficient reasons, finding that the following was insufficient:

"The reason for this [denial] is that the medical documentation does not support the need for OT sessions as described in the OT report of February 28, 2016. The OT also appears not be pursuing the plan that had been laid out by Mr. Bachman, Vocational Rehabilitation Specialist. Given the lack of evidence, an Insurer's Examination is required to address the eligibility for medical/rehabilitation benefits."

In concluding that the reasons were invalid, Executive Chair Lamoureux criticized the insurer for providing "opaque" reference to unspecified "medical documentation", noting that this effectively provided no insight as to the reason for the denial. The Executive Chair indicated that the insurer should have drawn the insured person's attention to the specific documentation upon which it was relying, along with the relevant points therein, although an exhaustive list was not necessary. Finally, in finding that a review of the medical documentation could simply not support the insurer's stated position, Executive Chair Lamoureux concluded that insurers were not entitled to rely upon incongruous or contrived reasons.

The Divisional Court weighed in on the issue of sufficient reasons in the decision of Hedley v. Aviva Insurance Company of Canada, 2019 CarswellOnt 14987.

In a brief decision, the Divisional Court concluded that reasons for an insurer's decision must be meaningful enough to permit an insured person to decide whether or not to challenge the decision.

The Divisional Court again weighed in on the issue in the decision of Varriano v. Allstate, 2021 ONSC 8242*. In this decision, the Divisional Court provided a much more detailed outline of appropriate notice, concluding that the requirements as set out in M.B. and T.F. were "imminently reasonable baseline standards". As such, it is clear at this stage that reasons will require the following in order to be deemed sufficient:

1. Explanation of the insurer's decision with reference to the insured person's medical condition OR confirmation that the decision is not based on a medical reason, and any other applicable rationale;
2. If the decision is based on a medical reason - inclusion of specific details about the insured person's condition forming the basis for the insurer's decision or, alternatively, information about the insured person's condition that the insurer does not have but requires;
3. Reference to the specific benefit or determination at issue, along with any section of the Schedule upon which the insurer relies; and,
4. Clear plain and ordinary wording, in order to allow an unsophisticated insured person to make an informed decision to either accept or dispute the decision at issue.

*It should be noted that the Divisional Court's decision in Varriano has been appealed. While the Court of Appeal's decision will need to be reviewed once released, the decision of the Divisional Court remains the leading case on the issue of proper notice requirements at this time.

Medical AND Other Reasons

As noted, insurers are required to provide "the medical reasons and all of the other reasons" for their decisions. The Licence Appeal Tribunal had concluded on multiple occasions pre-Varriano that either medical or other reasons had to be provided, but not both. While the Divisional Court in Varriano did not expressly overrule this, it did confirm that reference must always be made to medical reasons, even if there is no medical reason for the decision. Accordingly, when providing notice insurers should always either give a medical reason for a denial, or explicitly state that the decision is not based on a medical reason.

Effect on the Limitation Period

Insurers have long relied upon the Ontario Court of Appeal's decision of Sietzema v. Economical Insurance, 2014 ONCA 111 to support a position that the two year limitation period will begin to run once clear and unequivocal denial notice is given, regardless of whether the notice reasons are correct. It is important to note that the Divisional Court in Varriano concluded that Sietzema was no longer good

law, on the basis that it considered the pre-September 2010 version of the Schedule, which did not require insurers to provide medical and other reasons. In doing so, Varriano effectively confirmed that no limitation period will apply with respect to benefits denied on the basis of insufficient reasons.

Post-Varriano Decisions:

A review of the decisions considering Varriano confirms that, at least for now, it is being strictly followed. It is clear that the following boilerplate statements, in and of themselves, will not constitute sufficient reasons:

i. Denial based on review of unspecified "medical documentation";
ii. Denial based on general statements that an insured person does not meet the relevant test, without explanation as to why they do not meet the relevant test;
iii. Denial based on a general statement of inability to determine whether the insured person is entitled to a benefit; and,
iv. Denial based on general reference to the proposed benefit being inconsistent with the insured person's diagnoses.

Additional Notice Requirements

While the focus of this article has been on providing sufficient reasons, it is equally important for insurers to adhere to other applicable notice requirements, such as the need to confirm that the insurer believes the Minor Injury Guideline applies, or the requirement to provide specific details regarding in person insurer examination assessments. A failure to comply with these requirements can and will lead to a finding that notice is deficient, irrespective of the validity of the medical and other reasons provided.

Conclusion:

As per the decisions cited, the case law with respect to the sufficiency of reasons now appears well settled. While the standards are quite onerous, ensuring that reasons in compliance with Varriano are provided will go a long way to limiting exposure stemming from deficient notice. As the old saying goes, an ounce of prevention is worth a pound of cure, and by adhering to the notice requirements outlined in this article, avoiding general boilerplate references, and making it clear whether or not denial is based on medical reasons, you can set your claims handling up for success, both now and in the future.

Geoff is a partner with the firm of Kostyniuk & Greenside Lawyers, practicing in the area of insurance defence and specializing in the area of no-fault statutory accident benefits. He has proudly acted as lead Counsel in numerous accident benefits dispute hearings since his call to the bar in 2013. He regularly presents to various insurance companies in Ontario on topics of interest in the accident benefits world.