

EFFECTIVELY MANAGING INSURANCE CLAIMS

**APPLYING COST CONTAINMENT STRATEGIES TO DISPUTE
RESOLUTION WITH INSURANCE CLAIMS**

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INTRODUCTION

In our busy practices we are faced with an enormous volume of documents both in our tort and accident benefits cases. It is not only time consuming to keep on top of all our cases with the phone calls, letters and pleadings that have to be handled, but it is also extremely difficult to stay on top of legislative, procedural and substantive changes that take place in our industry.

It has become increasingly imperative to be able to get to the bargaining table early so that the case can be resolved before it becomes too costly for your client. Clients are generally becoming more knowledgeable about the process of litigation and prefer to have earlier opportunities to resolve their cases at a reasonable value rather than waiting several years to get the chance at full compensation. In dealing with accident benefits, there is generally a short margin for success if a claimant pursues litigation as the costs can quickly absorb the amount in dispute.

The Financial Services Commission of Ontario (“FSCO”, formerly the Ontario Insurance Commission) was created on July 1, 1998 as an arm's length agency of the Ministry of Finance, to regulate insurance disputes. Presently, FSCO provides two dispute resolution services: Designated Assessment Centres and mandatory Mediation.

The Statutory Accident Benefit Schedule (“SABS”) outlines the applicant’s so called “Bill of Rights” and the Dispute Resolution Practice Code outlines the rules of procedure. It would be too cumbersome to focus on all of the provision of the SABS and the Practice Code in one paper. Rather, it is worthwhile to compare the provisions pertaining to assessments and mediations, as they can be the most common steps a practitioner is confronted with in their accident benefit practice.

USING SECTION 24 EXAMINATIONS TO RESOLVE DISPUTES

Under Bill 59 (auto accident insurance claims after November, 1996), section 24 of the SABS sets out the provisions as to when the insurer will pay examination costs. It provides that:

24.(1) The insurer shall pay for all reasonable expenses incurred by or on behalf of an insured person for the purpose of this Regulation in obtaining and attending an examination or assessment or in obtaining a certificate, report, or treatment plan including

(a) fees charged by a person who conducts an examination or assessment or provides a certificate, report or treatment plan; (...)

This is a new provision under Bill 59, which provides for payment of reasonable expenses for examinations. As counsel for applicants are finding it increasingly more difficult to fund assessments in order to assist their clients to obtain necessary treatment, they would be wise to have appropriate assessments paid for by the claimant’s insurer under this section.

There is a body of law emerging due to the fact that plaintiffs have been using this provision to get their version of an insurance examination. Alternatively, insurers have been fighting this section on the basis that if they have completed an assessment already any additional assessment is duplicative and thus unnecessary.

What is at stake from a plaintiff's perspective is the ability to obtain a quasi med-legal assessment at the expense of the insurer.

The following FSCO arbitrations held the insurer responsible for paying for the claimant's s.24 assessment:

- *Tesfai*, Summer of 2000 (McMahon, arbitrator)
- *Tsimidis*, August, 2000 (McMahon, arbitrator)
- *Glinka & Dufferin Mutual*, November 21, 2000 (Kaye Joachim, arbitrator)
- *Sivanesan & CIBC*, January 11, 2001 (Tanja Wacyk, arbitrator)
- *Phu & State Farm*, December 5, 2000 (Anne Some, arbitrator)
- *Mostajo & Wawanesa*, January 16, 2001 (David Leich, arbitrator)
- *Stellino & Halifax*, January 26, 2001 (Tanja Wacek, arbitrator)

The following FSCO arbitration decisions held that the insurer was not required to pay the claimants s.24 assessment:

- *MD & Halifax*, Fall of 2000 (Draper, arbitrator)
- *Aleman & State Farm Insurance*, March 6, 2001 (Julian Palmer, arbitrator)

Overall, the arbitrations have held that s.24 assessments require the following three key elements to be present in order for the assessment to qualify:

- 1) The claimant has obtained a certificate, report or treatment plan from the assessment;
- 2) The assessment was for the *purpose of this Regulation*;
- 3) The expense was *reasonable*.

USING THE DAC PROCESS TO FACILITATE EARLY RESOLUTION OF CLAIMS

Designated Assessment Centres were introduced in January of 1994 as part of the changes to the automobile insurance compensation system under Bill 164. The DAC system was retained with the introduction of Bill 59 in November 1996.

The objective of the DAC system is to provide both claimants and insurers with a neutral third opinion about a claimant's entitlement to insurance benefits. The premise was that an impartial assessment would be instrumental in facilitating an early resolution of disputes between the insurer and the claimant.

The DAC assessment is unique from other examinations as it was created by statute and is governed by various guidelines, protocols and manuals applicable to the specific DAC. Failure to comply with the regulations may lead to a finding that little weight should be given to the DAC report or nullification of the report. The DAC centre may also be suspended or eliminated from the DAC roster of approved centres if is non-compliant with the governing regulations.

ABOUT DESIGNATED ASSESSMENT CENTRES

Bill 164 introduced, and Bill 59 continued, the use of designated assessment centres. The following DACs are contemplated by the following sections:

Bill 164	Ontario Regulation 776/93
Section 26	Rec DAC
Section 38	Medical Rehabilitation DAC
Section 49	Attendant Care DAC
Section 63	Disability DAC
Bill 59	Ontario Regulation 403/96
Section 43(5)	Disability DAC
Section 43(6)	Medical Rehabilitation DAC
Section 43(7)	Attendant Care DAC
Section 43(8)	Catastrophic Impairment DAC

Using the DAC system as a cost cutting measure requires counsel to be creative. Opportunities can arise with insurers where an appropriate DAC assessment or referral may resolve a particular dispute with the claimant. Oftentimes, however, the DAC ends up being a prerequisite for mediation, another stumbling block in the course of the dispute. The DAC process is highly regulated and, thus in order to effectively represent your client, efforts must be made to scrutinize the DAC and ensure that the DAC is:

- a) Properly qualified;
- b) Complying with recent arbitration decisions; and

c) Complying with the DAC guidelines.

(a) The qualifications of the health professional conducting the designated assessment:

DAC's are approved by the Minister's DAC Committee. The background and supporting information supplied with the DAC's application for designation is available on the FSCO website¹. These records will give you considerable information about the qualifications of the individual(s) writing the reports. Consider whether the DAC is also doing private assessments exclusively for insurers. Reports from these assessors will usually favour a return to functionality.

In addition, it is also appropriate to determine and know the identity of the DAC facility ownership. You are entitled to know who pays the DAC. You are also entitled to know who owns the DAC. There are conflict of interest guidelines required on the OCF-7A form.

There are pre-approved guidelines for each type of DAC. Copies of these guidelines are available from the FSCO. You are also entitled to avail yourself of the benefits of the complaints committee of the Accident Benefits Unit of the FSCO. Written complaints about DACs, which are received are kept by FSCO and may be accessed using the provisions of the *Freedom of Information and Protection of Privacy Act*. You may wish to file your own complaint if the DAC has conducted the assessment inappropriately or outside the scope of its mandate.

FSCO publishes a list of DAC's and their location together with the type of impairment that they are authorized to assess and the type of assessments they are authorized to conduct. These

¹ FSCO's website is "www.fSCO.gov.on.ca/"

documents can be one of the most important ways that counsel can ensure that their client is being assessed by an appropriate DAC.

(b) Recent Decisions regarding DACs

1. The Role of the DAC: *Walker v. State Farm* (File P-96-00036) stands for the proposition that DAC assessments are to be given no more weight than any other report.
2. MED REHAB DAC's: *Violi v. General Accident* (File A980-000670) upheld on Appeal (File P99-00047), September 27, 2000 and *Murray v. Wawanesa* (File A-003224) stand for the proposition that for treatment to be “reasonable and necessary”, it does not have to “promote recovery”. Pain relief is a sufficient goal.
3. Disability DACs: *Cook v. State Farm* (File A96-001284) stands for the proposition that the disability DAC cannot provide a prognosis for recovery. They can only provide a “snap shot in time”.
4. DAC Referral Package: *Traders General v. Levey* (File P98-00035) stands for the proposition that the insurer cannot provide negative, one-sided information to the DAC. This is now codified in the OCF-11A Referral Form.
5. DAC Neutrality: *Dehir v. Non-Marine Underwriters* (File A96-001160) stands for the proposition that a DAC cannot advocate for the insurer.

6. Failure to Consider Essential Tasks of Employment: *White v. Canadian Surety* (File A96-001554) and *Rutledge v. Wawanesa* (File A96-001160) stand for the proposition that the DAC has an obligation to find out what the essential tasks are.
7. Objective Findings and Evidence: *Redman v. State Farm* (File A-98-001239) and *Lopez v. State Farm* (File A97-00378) stand for the proposition that objective findings are not required for there to be impairment or disability.
8. Causation: *AB v. Royal Insurance* (File A97-000943) stands for the proposition that injuries do not have to be the sole cause of a disability (*Athey v. Leonati* principle). Lack of objective evidence does not disentitle claimant.
9. Malingering: *White v. Canadian Surety* (File A-96-001544) stands for the proposition that DACs cannot allege “malingering” unless they have described the malingering test used.
10. Credibility: *Singh v. General Accident* (File A99-00036) stands for the proposition that credibility assessments cannot be based solely on demeanor.

(c) DAC Guidelines

From time to time, FSCO makes guidelines to further strengthen the DAC system. Here are the highlights of some of the changes that have been implemented.² The following is a summary of the current guidelines which regulate DAC facilities:

1. Surveillance: The claimant must be advised of the existence of surveillance and is entitled to respond to the video
2. Production Requests
3. Permission to Disclose Health Information to DACs (OCF-14)
4. Ensuring Neutrality of the DACs
5. Conflict of interest and nearest DACs
6. Guide for conducting Medical and Rehabilitation Assessments
7. Guide for conducting Disability Assessment

MAKING A SUCCESSFUL MEDIATION

Dispute Resolution is the trend not only in cases before FSCO but also in all areas of litigation. While the Dispute Resolution Code and *Insurance Act* require mediation, claimants and insurers are becoming more cognizant of the costs of litigation and therefore are focused on resolving disputes.

² Copies of the guidelines are found in the appendix

In order to make a mediation successful, it is necessary to have a problem solving approach or an “interest based” negotiation technique. Parties who are “positional” will ignore the other parties' interest and will not have the flexibility to create a settlement that allows both parties to achieve their goals.

Because the mediator has no authority to impose a decision, nothing will be decided unless both parties agree to it. Knowing that no result can be imposed from above greatly reduces the tension of all parties, and it also reduces the likelihood that someone will cling to an extreme position. If mediation does not produce an agreement, either side is free to sue or to propose binding arbitration.

A successful mediation requires preparation not only for yourself but also for your client. It is imperative that you review what, if any, concessions that can be made. It may also be useful to consider the scenarios that are likely to transpire during the mediation. In order not to lose perspective, keep in mind your opposing party's interests, concerns and fears. Finally, your client must understand what is at stake if a resolution is not reached.

Compared to a lawsuit, mediation is swift, confidential, without prejudice, fair and fairly inexpensive. Mediation sessions can usually be scheduled within a few weeks or, at most, a couple of months from the time of request. Most sessions last only a few hours to a day, whereas lawsuits often take many months or even years to resolve.

If the accident occurred on or after November 1, 1996, mediations may involve one or more of the following benefits:

- Income replacement benefits
- Caregiver benefits
- Non-earner benefits
- Medical benefits
- Rehabilitation benefits
- Attendant care benefits
- Compensation of other expenses
- Death benefits
- Funeral expenses
- Case manager services

(a) Types of Disputes

Disputes over accident benefits may occur for any number of reasons, including a breakdown in communications, conflicting medical information or lack of exchange of information. Disputes predominately fall into two categories:

- whether or not a person is entitled to benefits; or
- how much of a benefit is owed

Entitlement issues can include:

- what types of benefits, if any, the person should receive; and

- how long the person should receive the benefits

Settlement is not the only positive outcome of mediation. A mediation is still considered successful even if the parties do not settle but gain a better understanding of the other side's position, if they have narrowed the issues or have settled some of the issues or if they have agreed on a process to resolve issues later in the proceedings. Lawsuits that do not settle at mediation may continue either through the Court process or FSCO arbitration.

CONCLUSION

While accident benefit practices have the tendency to involve several disputes which can form their own basis for litigation, it also has a built in settlement process that can assist you in keeping your costs to a minimum. As advocates, we are trained to argue and advance the interests of our client. However, in the present climate, the focus is on dispute resolution. The ability to eloquently articulate your client's position is certainly important. However the skill of listening has become equally essential in order to negotiate a reasonable settlement for your client.