From Augustin to the LAT: The Need to Provide Proper Notice in the Denial of Medical/Rehabilitation Benefits

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A recent reconsideration decision from the Licence Appeal Tribunal in *M.F.Z. v Aviva Insurance Canada*1 has followed a FSCO decision and once again highlighted the importance of providing the required reasoning when denying medical/rehabilitation benefits and the significant consequences resulting from non-compliance.

Section 38(8) of the SABS sets out what the insurer must do when it denies medical/rehabilitation benefits. This includes identifying the goods and services described in the treatment plan 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 or services, or the proposed costs of them, not to be reasonable and necessary.

Section 38(9) highlights that, if the insurer believes that the Minor Injury Guideline (MIG) applies to the insured person's impairment, the notice under subsection (8) must so advise the insured person.

Under s. 38(11), if the insurer fails to give notice in accordance with s. 38(8), the insurer is prohibited from taking the position that the MIG applies and is required to pay for all goods, services, assessments and examinations described in the treatment plan that relate to the

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period starting on the 11th business day after the day the insurer received the application and ending on the day the insurer gives notice described in subsection.

In the FSCO decision of *Augustin and Unifund Assurance Company* (FSCO A12-000452, November 13, 2013),2 Arbitrator Sapin emphasized the need for the insurer to provide medical reasons when denying a medical benefit and also to specify that it believes the MIG applies rather than using vague language. Arbitrator Sapin ultimately found the insurer responsible for full payment of the treatment plans in dispute due to the inadequate reasons provided.

In the reconsideration decision of *M.F.Z. v Aviva*, Executive Chair Linda Lamoureux was asked to reconsider a decision by the Tribunal wherein it found that, since Aviva's responses and denials of certain treatment plans failed to comply with the notice requirements under s. 38(8) and s. 38(9), Aviva was prohibited from ever taking the position that the MIG applies and was responsible for payment of the benefits.

In her decision, the Executive Chair highlighted that a reconsideration as set out in rule 18.2(b) of the Tribunal's *Rules of Practice and Procedure* will not be granted unless the Tribunal made a significant error in law or fact such that the Tribunal would likely have reached a different outcome.

The Executive Chair noted that the Tribunal found that Aviva did not provide medical reasons and all other reasons why it considered the treatment plans at issue not to be reasonable and necessary and was, therefore, non-compliant with s.38(8).

In addition, Aviva did not comply with s. 38(9) as it did not advise the claimants that the MIG applies. As such, the Tribunal held that the insurer was prohibited from taking the

2 This was the first decision to interpret the notice requirements in the SABS - O. Reg. 34/10, which includes a requirement for insurers to provide "medical reasons and all of the other reasons" when denying medical and rehabilitation claims.

position that the claimant's impairments fell within the MIG and was required to pay for all the goods and services recommended until it gave the claimants proper notice.

The Executive Chair noted that the Tribunal was "guided" by the decision of Arbitrator Sapin in *Augustin* and she agreed with the Tribunal's determination that the medical reason provided by Aviva did not constitute a medical reason at all (i.e. "the frequency of care does not generally diminish over time") and, therefore, did not comply with s. 38(8).

Moreover, while Aviva referenced the $3,500 MIG limit, it did not state that the insurer believes the MIG applies. As such, she agreed with the Tribunal that Aviva was non-compliant with s. 38(9) and that the insurer is prohibited from raising the MIG in the context of the treatment plans at issue and throughout the entire accident benefits claim (the insurer may still dispute entitlement to future medical benefits on the basis that the treatment is not reasonable or necessary).

Notably, the Executive Chair found that the Tribunal made an error with respect to the quantum of entitlement of one claimant since Aviva had subsequently cured its non-compliance as outlined in s. 38(11)2 (specifying that the insurer shall pay for benefits until it gives proper notice). As such, she held that Aviva is not responsible for payment of treatment incurred after the date proper notice was given.

This decision demonstrates the importance of strictly complying with s. 38(8) and s. 38(9) of the SABS in order to preserve the insurer's ability to dispute the medical/rehabilitation benefit claimed and also to preserve the right to assert that the claimant's injuries fall within the MIG. A failure to do so will result in the insurer being required to pay for the benefit claimed.

However, it is important to remember that in the event there is deficient notice given, the insurer must take steps to ensure that errors are remedied and proper notice is given so as to limit the amount the insurer must pay to only the benefits incurred during the period of non-compliance.