TIERNEY STAUFFER LLP

BARRISTERS & SOLICITORS

IF YOUR PATIENT HAS A DISPUTE OVER THE DENIAL OR TERMINATION OF A BENEFIT

(1) Rebuttal Exams

If a treatment plan or a benefit has been denied or terminated for your patient, there is a procedure available to your patient to dispute the denial or termination of a benefit.

As the original provider or the one who approved the treatment plan or disability certificate, you are able to perform an assessment relating to entitlement to ongoing benefits.

In order for the accident benefits insurer to deny the treatment or benefit, they must arrange an insurer examination by a health practitioner of their choosing pursuant to section 42 of the *Statutory Accident Benefits Schedule.* If, as a result of the assessment, a benefit is denied or terminated, you may be asked to respond in the form of a “Rebuttal Exam”.

The rebuttal report can address the portions of the report with which you do not agree and that are relevant to the denial of the claim.

If you are asked to prepare a rebuttal report, please note that you only have 40 business days from the date of their letter advising that they are not going to provide the benefit, to conduct an assessment or examination. If your rebuttal examination does not require a re-assessment, but a review of the materials only, the maximum amount payable is **$450.00** for this report and the insurance company **must pay** this amount without dispute.

If your rebuttal examination is not limited to a review of the material and you must meet with your patient, the amount payable is **$900.00** if you practice medicine in a speciality other than family medicine, or **$775.00** if the assessment is conducted by any other members of the health care profession.

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These amounts shall be payable within 30 days after an invoice is sent to the insurance company. Also, it is important to note that if the patient has been deemed catastrophic, the time lines for the rebuttal reports are increased to 60 business days.

Please read section 42.1 of the *Statutory Accident Benefits Schedule* by accessing the following link: http://www.e-laws.gov.on.ca/Download?dDocName=elaws_reg_960403_e or reading the attached.

(2) Mediation/Arbitration or Litigation

After the insurer receives your rebuttal report, they may or may not change their mind with respect to paying the benefit. In the event that the insurance company continues to deny the treatment or benefit, there is a procedure available to your patient to dispute the termination or denial of the benefit.

A comprehensive overview of how to dispute the denial or termination of a benefit can be found on the Financial Services Commission of Ontario website at www.fsco.gov.on.ca or can be obtained by calling the toll free number 1-800-668-0128.

Patients should be informed that if a benefit has been terminated or denied by the insurer, action must be taken to dispute the termination or denial of the benefit within **two years** after the insurance company refuses to pay the amount claimed.

The patient should contact a lawyer immediately if a benefit has been terminated or denied.

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EXAMINATION REQUIRED BY INSURER

42. (1) For the purposes of assisting an insurer to determine if an insured person is or continues to be entitled to a benefit under this Regulation for which an application is made, an insurer may, as often as is reasonably necessary, require an insured person to be examined under this section by one or more persons chosen by the insurer who are members of a health profession or are social workers or who have expertise in vocational rehabilitation. O. Reg. 546/05, s. 21.

(2) Subsection (1) does not apply with respect to,

(a) a benefit to which section 37.1 applies, other than an amount claimed for ancillary goods or services referred to in section 37.2; or

(b) a funeral benefit or death benefit. O. Reg. 546/05, s. 21.

(3) Subject to subsection (7), each of the following examinations under this section shall be limited to an examination of material provided under subsection (10) in respect of the insured person without requiring the attendance of the insured person:

1. An examination for the purposes of section 37.2 to assist the insurer in determining whether to pay for ancillary goods or services claimed by the insured person.
2. An examination after an application is made under section 38 to assist the insurer in determining if the insured person has an impairment to which a *Pre-approved Framework Guideline* applies.
3. An examination for the purposes of section 38 to assist the insurer in determining whether to pay for goods or services contemplated by a treatment plan if the goods and services are substantially similar to goods or services the insurer previously refused to pay for when they were included in a previous treatment plan submitted to the insurer on behalf of the insured person in respect of the same accident.
4. An examination for the purposes of section 38.2 relating to an application for approval of an assessment or examination.
5. An examination for the purposes of section 40 that relates only to the issue of whether the insured person has a brain impairment that results in a score of 9 or less on the Glasgow Coma Scale referred to in subclause 2 (1.2) (e) (i). O. Reg. 546/05, s. 21.

(4) Whenever the insurer requires an insured person to be examined under this section, the insurer shall arrange for the examination at its expense and shall give the insured person a notice setting out,

(a) the reasons for the examination;

(b) the type of examination that will be conducted and whether the attendance of the insured person is required during the examination;

(c) the name of the person or persons who will conduct the examination, the regulated health professions to which they belong and their titles and designations indicating their specialization, if any, in their professions; and

(d) if the attendance of the insured person is required at the examination, the day, time and location of the examination and, if the examination will require more than one day, the same information for the subsequent days. O. Reg. 546/05, s. 21.

(5) If the insurer has already notified the insured person under this Regulation that the insurer requires the insured person to be examined under this section, the insurer shall give the notice required under subsection (4),

(a) not more than two business days after the previous notice was given, if the attendance of the insured person is not required at the examination, unless the examination is for the purposes of assisting the insurer determine if the insured person has a catastrophic impairment; or

(b) not more than five business days after the previous notice was given and, unless the insured person and the insurer mutually agree otherwise, not less than five business days before the examination, if the attendance of the insured person is required at the examination or if the examination is for the purposes of assisting the insurer determine if the insured person has a catastrophic impairment. O. Reg. 546/05, s. 21.

(6) If the insurer is not authorized under another section of this Regulation to give the insured person notice that the insurer requires the insured person to be examined under this section, the insurer shall give the insured person the notice required under subsection (4) not less than five business days before the examination, unless the insured person and insurer mutually agree otherwise. O. Reg. 546/05, s. 21.

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(7) If a notice under subsection (4) indicates that the attendance of the insured person is not required for the examination and it is subsequently determined by the person conducting the examination that the insured person should be in attendance and personally examined, the insurer shall give a notice to the insured person within two business days after the day the notice described in subsection (4) is given and at least five business days before the examination,

(a) notifying the insured person of the change in the type of examination;

(b) requiring the attendance of the insured person at the examination; and

(c) setting out the day, time and location of the examination and, if the examination will require more than one day, setting out the same information for the subsequent days. O. Reg. 546/05, s. 21.

(8) A notice under subsection (4) or (7) may be verbal if a written confirmation is given as soon as practicable afterwards. O. Reg. 546/05, s. 21.

(9) The following applies if the attendance of the insured person is required at an examination:

1. The insurer shall make reasonable efforts to schedule the examination for a day and time that are convenient for the insured person.
2. Subject to paragraph 3, the examination must be conducted, unless the insured person otherwise consents, at a location that is not more than,
   i. 30 kilometres from the insured person's residence, if the residence is in the City of Toronto or in The Regional Municipality of Durham, The Regional Municipality of Halton, The Regional Municipality of Peel or The Regional Municipality of York, or
   ii. 50 kilometres from the insured person's residence, if the residence is not in a municipality described in subparagraph i.
3. If, after taking reasonable steps, the insurer is unable to arrange for a qualified person to conduct the examination at a location within the distance required under subparagraph 2 i or ii, as applicable, the insurer may arrange for the examination to be conducted by a qualified person at a location that is reasonable in the circumstances. O. Reg. 546/05, s. 21.

(10) For the purposes of the examination,

(a) the insured person and the insurer shall, within five business days after the day the notice of the examination under subsection (4) or (7) is received by the insured person, provide to the person or persons conducting the examination all reasonably available information and documents that are relevant or necessary for the review of the insured person's medical condition; and

(b) if the attendance of the insured person is required at the examination, the insured person shall attend the examination and submit to all reasonable physical, psychological, mental and functional examinations requested by the person or persons conducting the examination. O. Reg. 546/05, s. 21.

(11) Subject to subsection (12), if the insured person complies with subsection (10), the person or persons conducting the examination shall complete the examination, prepare a report of their findings and provide a copy of the report to the insurer in accordance with the following:

1. If the attendance of the insured person was not required for the examination, the examination must be completed and a copy of the report provided to the insurer,
   i. not more than 10 business days after the day the notice of the examination under subsection (4) was given to the insured person, if the examination relates to whether the insured person has a catastrophic impairment, or
   ii. not more than five business days after the day the notice of the examination under subsection (4) was given to the insured person, in any other case.
2. If the attendance of the insured person was required at the examination and the examination relates to whether the insured person has sustained a catastrophic impairment or, if the insured person has sustained a catastrophic impairment, relates to whether the insured person is entitled to medical benefits, rehabilitation benefits, specified benefits under section 35 or attendant care benefits,
   i. the examination must be completed not more than 30 business days after the day the notice relating to the examination was given under subsection (4) or, if a notice was given under subsection (7), 30 business days after the day that notice was given, and
   ii. a copy of the report of the examination must be given to the insurer not later than 10 business days after the day the examination was completed.

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ASSESSMENT OR EXAMINATION AFTER DENIAL OF BENEFITS

42.1 (1) In this section, "original provider" means, in respect of an insured person, the member of a health profession who, in accordance with this Regulation, approved the treatment plan, prepared the assessment of attendant care needs, completed the disability certificate or prepared the application under section 40, as applicable, that was submitted to the insurer with respect to the insured person. O. Reg. 546/05, s. 21.

(2) This section applies in respect of an insured person if the following conditions are satisfied:

1. An examination of the insured person was conducted under section 42 and the insurer gave to the insured person a copy of the report of the examination and the insurer's determination.
2. The insurer's determination is,
   i. that the insured person is not entitled to benefits, if the examination related to a claim for benefits, or
   ii. that the insured person does not have a catastrophic impairment, if the examination related to an application under section 40.
3. The examination under section 42 was not related to,
   i. a claim for ancillary goods or services referred to in section 37.2, or
   ii. an application under section 38.2 for approval for an assessment or examination.
4. The examination under section 42 was not for the purposes of assisting the insurer determine if the insured person has an impairment to which a *Pre-approved Framework Guideline* applies.
5. If the examination under section 42 related to a claim for a specified benefit under section 35, no assessment or examination relating to that benefit has been conducted previously under this section.
6. If the examination under section 42 related to a claim for an attendant care benefits under section 39, no assessment or examination relating to that benefit has been conducted under this section within the previous 12 months.
7. The examination under section 42 was not an examination to which subsection 42 (6) applied. O. Reg. 546/05, s. 21.

(3) The insurer shall pay fees in accordance with this section for an assessment or examination of the insured person and for the preparation of a report of the assessment or examination if the following conditions are satisfied:

1. The assessment or examination and the report of the assessment or examination are limited to the portions of the report of the examination under section 42 with which the insured person does not agree and that are relevant to the denial of the claim or application.
2. The assessment or examination is conducted by one or more members of a health profession who are authorized under this section to conduct the assessment or examination.
3. If the insured person has sustained a catastrophic impairment or the examination under section 42 relates to whether the insured person has sustained a catastrophic impairment, the assessment or examination under this section is conducted and the report provided to the insurer not more than 80 business days after the day the insurer gave the insured person notice of its determination.
4. If the insured person has not sustained a catastrophic impairment and the examination under section 42 does not relate to whether the insured person has sustained a catastrophic impairment, the assessment or examination is conducted and the report is provided to the insurer not more than 40 business days after the day the insurer gave the insured person notice of its determination. O. Reg. 546/05, s. 21.

(4) Subject to paragraph 2 of subsection (3) and subsections (5) and (6), an assessment or examination under this section must be conducted by the original provider or, if the insured person had more than one original provider, the original provider designated by the insured person. O. Reg. 546/05, s. 21.

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(5) The assessment or examination under this section may be conducted by any person who is a member of any health profession if,

(a) the original provider is not a member of the same health profession as the person who conducted the examination under section 42; or

(b) the original provider is a member of the same health profession as the person who conducted the examination under section 42, but is not legally authorized to practise in the same specialty. O. Reg. 546/05, s. 21.

(6) If members of two or more health professions conducted the examination under section 42, the assessment or examination under this section may be conducted by one or more persons other than the original provider. O. Reg. 546/05, s. 21.

(7) The assessment or examination under this section shall be limited to an examination of the material provided under subsection 42 (10) to the person who conducted the examination under section 42 if,

(a) the examination under section 42 was conducted by a person who,

(i) is a member of the same health profession as the original provider, and

(ii) is legally authorized to practise in the same specialty as the original provider, if the original provider is legally authorized to practise in a specialty;

(b) the examination under section 42 was limited to an examination of the material provided under subsection 42 (10) to the person who conducted that examination; or

(c) the assessment or examination relates to a claim for medical benefits or rehabilitation benefits and an assessment or examination of the insured person with respect to the same accident has been conducted under this section within the previous 12 months. O. Reg. 546/05, s. 21.

(8) If the insured person does not have a catastrophic impairment and the assessment or examination under this section does not relate to whether the insured person has a catastrophic impairment, the total amount payable for an assessment or examination under this section, for the preparation of the report of the assessment or examination and for any related expenses permitted under section 24 shall not exceed the amount determined as follows:

1. If the assessment or examination is limited to, or required by this section to be limited to, an examination of the material provided under subsection 42 (10), the maximum amount payable is $450.

2. If the assessment or examination is not limited to nor required by this section to be limited to an examination of the material provided under subsection 42 (10), the maximum amount payable is,

i. $900 if the assessment or examination is conducted by one or more members of a health profession and at least one of them is a physician who is legally authorized to practise in a medical specialty other than family medicine, or

ii. $775 if the assessment or examination is conducted by one or more members of a health profession and none of them are physicians described in subparagraph i. O. Reg. 546/05, s. 21.

(9) Amounts payable under this section shall be paid by the insurer within 30 days after receipt of an invoice for the amounts. O. Reg. 546/05, s. 21.

(10) An assessment or examination under this section shall be used only for the purposes of assisting in the resolution of a dispute in accordance with sections 280 to 283 of the Act and the insurer is not required as a result of receiving the report of the assessment or examination to allow any application or pay any benefit that it otherwise would not have allowed or paid. O. Reg. 546/05, s. 21.

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