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Section 24 Expenses: When, What, and Why Do I Need To Pay? (An Update 2004-2007)

On October 1, 2003 the *Schedule* was substantially revamped to limit the proliferation of unwanted section 24 assessments. Beforehand, the accident benefits insurer was paying for its own assessments and essentially funding the claimant's case as well. Recent decisions between 2004-2007 have strengthened the procedural manner in which an insurer can deny payment for a section 24 expense and re-affirmed the manner in which the substance of the report has been assessed to determine if it ought to be paid.

Section 24 requires an insurer to pay reasonable fees charged by a health practitioner for preparing an assessment provided that it was reasonably required in connection with a benefit claimed or in the preparation of a treatment plan. Since 2004, Arbitrators have consistently found that if the claimant does not seek prior approval for the assessment than an insurer is not obligated to pay for the assessment strictly based on this procedural argument (*Tan v. Royal and Sunalliance* [2004], *Pereira v. Kingsway General Insurance Company* [2005], *Patriarca v. State Farm* [2006]). There appears to be unanimity at FSCO with respect to this procedural requirement without any analysis as to the utility of the substance of the assessment (there does not appear to be any Court rulings on this issue yet). So, if the claimant does not seek prior approval, then an insurer is on quite solid footing to refuse to pay for the assessment; regardless of the merit of the report.

Once this procedural requirement is fulfilled, (i.e. asking the insurer to pay for the report), the analysis appears to switch to substance over procedure. In *Borissenko v. RBC* (2007), the insurer obtained an insurer examination in-home assessment which came to the conclusion that the claimant was entitled to 7.2 hours worth of housekeeping benefits. The claimant requested payment for his own section 24 in-home assessment which was denied on the basis of a fast track DAC assessment. Nonetheless, the claimant obtained the section 24 assessment anyway within three weeks of the insurer examination which came to the conclusion that the claimant required 8 hours of weekly housekeeping assistance. The Arbitrator concluded that the section 24 assessment was virtually identical to the insurer examination and that no viable explanation was provided as to why such an assessment was "reasonably required". However, the Arbitrator did indicate that had the claimant provided evidence as to why the insurer examination was deficient, then it may then have been reasonable to have requested funding for their own assessment. The Arbitrator somewhat set-out a framework that claimants may use in the future to seek payment of section 24 assessments.

In *Patriarca v. State Farm* (2006), the Arbitrator was asked to determine whether a section 24 report prepared by an orthopaedic surgeon was reasonably required even though it too had been denied by the insurer via a "fast track" DAC. In that case, the

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fast track assessor conceded on the stand at the Arbitration that seeing a patient is better than merely reviewing a file, and that medicine is not an "exact science". The Arbitrator accepted that the assessment performed by the orthopaedic surgeon was reasonably required in order to assess the claim for housekeeping benefits. This case stands for the proposition that a section 24 assessment will be found to be payable if the assessment is done in person (carries more weight than a paper assessment), if it is a reasonable assessment, and that the proper procedures are followed.

Another area in which there is inconsistency in the law is the question as to when pre-judgment interest ought to be paid with respect to the denial of section 24 assessments. This becomes quite a substantial issue as interest, as per the *Schedule*, is payable at the rate of 2% per month compounded monthly (the cost of an unpaid benefit/expense is more than doubled after four years). In *Patriarca v. State Farm* (2006) the Arbitrator found that an insurer is not obligated to pay for pre-judgment interest on a section 24 assessment until an Arbitrator/Judge makes a decision as to entitlement (interest will then commence 30 days after the decision is rendered). However, in *Neumeyer v. Wawanesa Mutual Insurance Company* (2005) the Judge found that pre-judgment interest is payable 30 days after the report was originally submitted to the insurer. The latter decision makes it substantially more risky from a financial standpoint to deny payment of a section 24 expense and is clearly a bonus to the claimant.

For the most part, Judges/Arbitrators have determined whether a section 24 assessment is payable based on substance over procedure. In *Neumeyer v. Wawanesa Mutual Insurance Company* (2005) the section 24 assessment specifically addressed whether the claimant has suffered a threshold injury which clearly is a test for a claim in tort and not accident benefits. Nonetheless, since the substance of the report addressed whether the claimant was able to return to work, the Judge concluded that the purpose behind the report was to convince the insurer that the claimant was not employable. The assessment was ordered to be paid in full. In *Afiriyie v. TTC Insurance* (2005), the Arbitrator concluded that the section 24 assessments were conducted so long after the accident and were deficient in substance, that they were of no assistance to the assessment of the claim. In *K. v. Liberty Mutual* (2005) and *Kasun v. Aviva* (2007) the Arbitrators concluded that substantial and pivotal facts were either absent or so misrepresented by the claimant in the reports that the assessments were rendered useless. In *Urgiles v. Allstate Insurance Company* (2005), the Arbitrator denied the request for payment of a digital motion x-ray assessment on the basis that the cost was exorbitant, (less costly alternatives were available), and it was unclear how such an assessment would assist in diagnosis and treatment.

The one common theme that runs through the case law at present is that the claimant must seek pre-approval for a section 24 assessment. If he fails to do so, the report is not payable as a section 24 assessment. If pre-approval is sought and denied, then an Arbitrator/Judge will look to the substance of the report to determine to what extent the report adds value to an assessment of the claim. Although the change in the legislation has granted an insurer more weapons to curtail against the onslaught of unwanted section 24 assessments, it is still imperative to assess the substance of the report as opposed to maintaining only steadfast procedural defences.

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