

WHAT'S HAPPENING AT FSCO? THE LEGATE SABS UPDATE

For the week of March 23 to 27, 2009

Everything old is new again: Insurers obliged to evaluate and consider all reports, not just their own.

Butt and Lombard General Insurance Company of Canada, FSCO A06-001227, March 3, 2009, Arbitrator Suesan Alves

MVC October 3, 2003. The insured was working as a taxi cab driver when his vehicle was rear-ended. He had worked 12 years as a cab driver for 84 to 96 hours per week. Following the collision he attempted to return to work, however, he was unable to do so as a result of nerve root irritation and sciatica caused by the collision. Following a work hardening program he was able to work for two to three hours a day. A dispute arose over whether he met the post 104-week *complete inability* test.

The arbitrator held that he was completely unable to engage in a reasonably suitable job. The standard against which the disability was to be measured was the usual 14 to 16 hours per day that the insured worked prior to the collision. Due to problems with cognitive functioning, irritability and anger management he was not suited to other employment canvassed in vocational assessments. The combination of these factors rendered the insured completely unable to engage in a reasonably suitable job.

The insurer was ordered to pay a special award because it relied on the conclusions set out in medical and accounting reports it obtained without critically analyzing the reports and considering whether the opinions offered were consistent with the meaning of the *complete inability* test articulated in arbitral jurisprudence.

The insurer has an ongoing duty to consider information and opinions from all sources, and is not limited to the conclusions from insurer medical examinations, when adjusting a claim. Lombard paid for a section 24 neurological assessment that provided a neurological basis for the insured's back pain. Despite this assessment the insurer then proceeded to obtain an orthopedic opinion about the insured's level of ability to work. The insurer did not provide the orthopedic surgeon with a copy of the neurological report.

The arbitrator remains seized of the matter to determine the quantum of the special award until the insured's income replacement benefit is recalculated with interest.

Implications:



Insurers have an obligation to carefully review section 42 reports to determine whether the conclusions reflect both the findings outlined in the body of the report as well as the manner in which FSCO arbitration decisions define *substantial inability* and *complete inability* tests. Similarly, insured's counsel should be engaging in the same critical analysis to ensure this is being done by the insurer and that claims are being adjusted accordingly. In instances where it appears that this is not being done and decisions are made which affect an insured's entitlement to, or quantum of, benefits then it is open to pursue a claim for bad faith damages or a special award.

Accessing Arbitration Decisions

If you would like to read the arbitration decisions for yourself, they can be found at <http://www.fSCO.ca/english/insurance/auto/drs/decisions/default.asp>. Please contact FSCO at 1-800-517-2332 ext. 7202 to obtain a password to gain access to the site.