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September 23, 2024

Re: Budget Auto Insurance Reforms – FSRA Reviews
Professional Services Guideline/Attendant Care Hourly Rate Guideline/Health Claims for Auto Insurance system

Thank you for advising FAIR about the opportunity to speak to some of the issues coming up in the Budget Auto Insurance Reforms consultation planned for October 2024.

We appreciate the opportunity and our comments are predominately directed toward increased transparency and claimant access to their information on HCAI.

We have, over time, touched on these subjects at our past meetings with various FSRA staff.

FAIR has been outspoken on the unfair treatment of health service providers in a system focused on insurer profits rather than claimant outcomes. We firmly believe that payments to this important stakeholder group should be reviewed, adjusted, and indexed by the Regulator going forward. Health Service Providers (HSP) and Personal Support Workers (PSW) who are highly qualified to provide the needed care for injured car crash survivors, should be fairly compensated in order to retain the quality of care Ontario's claimants deserve.

Why don't claimants have read-only, real time access to the HCAI information which is about them and their claim, their injury and their treatment, their medical examinations and the billing from providers? A claim is about a person's injury and the allocation of funding for their healthcare needs and yet they are closed out of the process.

Currently insurers are the only organization who have full access to what benefits have been submitted, approved, etc through HCAI. Claimants should have access to information about where their claim dollars are going, to whom, and for what purpose at

every stage of the process including the Minor Injury Guideline (MIG) which is where over 80% of claims end up.

Claimants can currently access HCAI information from their insurer to track what is being billed in their names by either a statement that is supposed to be sent out to claimants (serious injury and CAT designations) or by request but the information they should have, may not be evident in what insurers send out in a Standard Benefit Statement.

As an example:
A claimant's provider submits an OCF18 for $3,200 worth of treatment. The insurer approves the plan subject to collateral benefits. Of this amount, the insured's employee benefits cover $2,000. After the provider completes the treatment plan and invoices the balance of $1,200 to the insurer, the insurance company at no time credits back the $2,000 from the $65,000, and the insurer continues to take the position that the insured only has $61,800 benefits left because $3,200 have been approved.

Eyes on the dollars from the initiation of a claim onward will eliminate opportunities for insurers and their intermediaries, assessment companies and providers, to take advantage of the claimant whose allocated dollars could be going places other than care without their knowledge. Claimant access to HCAI data is a way to prevent fraud for both insurers and claimants.

This is exactly why insurers should not be the only entity granted access to real-time HCAI data. It's not enough to say that upcoming proposed legislation to make insurers 'payors of first resort' will address this problem of 'fudging' the numbers. The legislation may not happen, and even if it does, the current information for MIG needs to be expanded and claimants still need to know where their claim dollars are going.

Since 80% of claims end up classified as MIG, this is a serious gap of accountability given many of the medical exams (IE/IME) are done at that threshold point of the transition into serious injury category and CATastrophic designation. This means that many medical examinations may escape attention and MVA survivors would not be aware they've been the subject of a 'missed and cancelled appointment' scheme where dollars are being funnelled to insurers' preferred IME vendors' pockets. Claimants will likely never figure out what has happened to them via their medical exams and how these cancelled appointments can be used to make them look uncooperative at a legal hearing later in the claim.

Below are some decisions that highlight the many ways these appointments are missed and/or cancelled. Some of the appointments should never have been arranged or are incompatible with the injury (outside of expertise). Many IMEs mentioned in the below decisions seem to be poorly timed in the claims process or were not agreed to by the claimants. This is information coming to light at the end of a claim and if insurer activity was monitored via HCAI it would be apparent and actionable earlier in the claim process

rather than a regulatory hole where many assessment companies appear to operate without any meaningful oversight.

How do we know this is a regulatory failing? It's clear in the Health Care Data Base Standard Report (HCDB) report that the cancellation fees are disproportionately high and represent a significant amount paid out by insurers to their friendly assessment companies. No one has been watching or taking action and the dollars flowing to assessing (including the cancellation fees) are higher than the dollars spent on recovery. Proactive attention is required.

Go to: https://www.ibc.ca/industry-resources/insurance-data-tools/health-claims-database-hcdb

Open Ontario Health Claims Database HCDB Standard Report – 2024H1 (July 2024)

See page 41 of the HCAI data in the HDBD report. See **Missed/Cancelled Appointments** (2013- 2015) and **Missed/Cancelled Appointments – IE** (2016-2024)

This is the same information about missed/cancelled appointments over the years, just different headings (designed to confuse). This report used to come out once a year. It is now calculated 2X per year - perhaps to have smaller numbers in some of the categories and the format has also recently changed.

You'll see under the 20241 column (Jan - July 2024) that **so far this year Ontario insurers have spent $642 per claim on missed and cancelled insurer examinations.**

In 2023 (20231 and 20232) **insurers spent between $876 and $1003 dollars per claim on missed and cancelled insurer exams**.

On pages 39 and 40 you'll see columns on **Insurer Initiated Exam** and **Provider Initiated Exam**. These are the costs of insurers examining claimants (IMEs and IEs) to determine what their injuries are. So far, in the first 6 months of 2024 insurers have spent per claim:

20241 **$467 for provider initiated exams** (your treatment provider does an examination at the request of the insurer)

20241 **$2,176 for insurer initiated exams** (IME (insurer medical examination) and IE (insurer examination))

That's **a total of $2,643 examining claimant injuries and $642 in missed and cancelled insurer examination appointments**

Total spent on investigating injuries $3285.00 per claimant in 20241.

If you look at page 38 - 39, the Treatment – Subtotal comes to **$1,547 spent on treatments in 20241.**

Insurers are spending twice as much examining claimants as they are treating those claimants. (this includes the cancellation fees)

It's hard to believe that every claimant missed an IME/IE appointment and the fees charged for these missed appointments are outrageous. We see it as a payment to friendly IME providers. And in our public system no one gets these inflated cancellation fees.

This type of “Missed IE appointment – cancelled with insufficient notice or no-show” billing is not isolated but because each case is siloed it only occasionally gets mentioned in the wording of court documents. Below are decisions that highlight the many ways these appointments are missed and/or cancelled.

The assessors themselves may not even know about the cancellation fee or may only get a small portion of it since the assessment business is now dominated by large assessment companies who may, or may not, pay the individual assessors any of the fees for cancellations they bill for.

In Martin v Haratsis, 2022 CanLII 49155 (ON HPARB), <https://canlii.ca/t/jpplx where the complaint included ***"unilaterally scheduled a follow-up appointment for February 15, 2017 and then issued a bill for the missed appointment"*** which was then sloughed off at the appeal stage by HPARB with:

53. As noted above, the Committee relied on its knowledge and expertise related to the expected standards of the profession in assessing the Respondent’s conduct and actions. The Committee’s knowledge would extend to an understanding of how business is conducted between physiotherapists conducting assessments and the insurance providers commissioning those assessments. The Board finds that it was not necessary for the Committee to identify any statutory authority to confirm its understanding of business procedures and the Board finds the Committee decision to take no action on the appointment scheduling and billing concerns to be reasonable.

A quick check of the Ontario Physiotherapists website shows no detail in respect to Third Party Billings, just vague references to *"fees charged are accurate and reasonable"* and *"Physiotherapists must never charge fees or create billings or accounts that are inaccurate, false or misleading".* Despite the familiarity with their own members being taken advantage of there is no explicit instruction on billing practices. See: https://www.collegept.org/case-of-the-month/post/case-of-the-month/2015/02/16/february-2015-pts-fight-back-against-shady-clinic . This lack of detail and failure to inform their members leaves the door wide open for these HSP to be taken advantage of. And doing nothing about this situation means that creative billing practices on the part of insurer assessment centers ensures they will face no sanctions when they take advantage of these providers. Mr. Haratsis is not on the FSRA HSP list. Was he paid by AssessMed for the missed appointment? How would he have even known about AssessMed charging for the appointment?

Are these cancelled and missed appointment costs subtracted from the already meagre coverage Ontario's claimants count on?

We can't tell you because claimants don't have access to that data.

We hope that this HCAI access issue will be one of the areas considered in the current consultation process to ensure the fair treatment of vulnerable consumers.

Thank you and we look forward to submitting on the upcoming consultation.

FAIR Association of Victims for Accident Insurance Reform

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Decisions on cancelled/missed IE/IME **(bolding added)**

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16-003144 v Cumis General Insurance Company, 2017 CanLII 22315 (ON LAT), <https://canlii.ca/t/h3b4w

39. Even though the insurer can delegate the design of the assessment process, they should use judgment in determining the number and nature of the examinations requested. There should not be a process of rounding up the "usual suspects".[13] ***In this case, however, there seems to be an element of this approach. Dr. Meikle testified that he ordered the occupational therapy examinations to support the psychiatric examination. In doing so, he testified that he was following the process under the former DAC system, which has long been discontinued. He candidly admitted that two occupational assessments were ordered rather than one to permit billing for each***.

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L.D. v Gore Mutual Insurance Company, 2022 CanLII 93715 (ON LAT),

<https://canlii.ca/t/jsbth

BACKGROUND

[1] The applicant was involved in an automobile accident on November 24, 2015 and sought an attendant care benefit pursuant to the *Statutory Accident Benefits Schedule - Effective September 1, 2010* ("Schedule"). The respondent denied the applicant's claim, so she submitted an application to the Licence Appeal Tribunal - Automobile Accident Benefits Service ("Tribunal").

[2] The respondent brings this motion for an order under s. 55 of the Schedule to bar the proceeding. Section 55 prohibits an application to the Tribunal where the applicant has failed to attend a properly scheduled insurer's examination ("IE") under s. 44 of the Schedule. The respondent alleges that the applicant has failed to attend three properly schedule IEs.

[3] Since the respondent filed the motion, events have moved forward, and the applicant has now been found to meet the definition for catastrophic impairment. She has advised the Tribunal that she wants to attend IEs so her claim can move forward to a final resolution. The alternate relief the respondent seeks is an order staying the proceeding until the applicant attends IEs. In the circumstances, I find that the most just, expeditious, and cost-effective manner to move this matter on to final resolution is the set a timetable for attendance at IEs to determine the applicant's entitlement to attendant care.

IE Appointments

[7] As stated above, **the respondent submits that [Ms. D] failed to attend at three IEs** – an assessment by Ranu Singh, Occupational Therapist ("OT"), scheduled for April 18, 2017; an assessment by Anna Matrosov, OT, scheduled for November 30, 2017; and a third assessment by Joan Saunders, OT, scheduled as a replacement for Ms. Matrosov and subsequently cancelled by the respondent. [Ms. D] submits that, if the notices were compliant with s, 44(5)(a), then she failed to attend one IE. In her submission, the respondent cancelled the others.

[8] In submissions, the respondent concedes that it cancelled the third IE because [Ms. D]'s entitlement to the benefit had expired. At that time [Ms. D] had not been found to be catastrophically impaired so she was limited to a two-year period of entitlement. The third IE was scheduled after the expiry of the two years and the respondent was of the opinion that it no longer had the right to require [Ms. D] to attend IEs for attendant care. By virtue of her catastrophic impairment designation [Ms. D] is now entitled to attendant care for life or until the policy limits have been exhausted.

[9] **Of the two remaining IE appointments, the respondent concedes that it cancelled the second appointment, but in circumstances where [Ms. D]'s counsel had tainted the process by communicating directly with the respondent's assessor. Other than identifying the exchange between counsel and the assessor, the respondent does not expand on why the assessment did not go ahead.** It appears to take the position that it is self-evident that its assessor was compromised in some manner, stating in its factum:

Given the direct communication that had occurred between the Applicant's counsel and the IE assessor, and concerns relating to the assessor's impartiality arising therefrom, the examination did not proceed as scheduled.

[10] I find it far from self-evident, without further evidence of impropriety, that communications between counsel and an assessor retained by the other party would have any material impact on the assessor's objectivity and professionalism rendering her unable complete the assessment to the best of her ability. **In these circumstances, the cancellation of the November 20, 2017 assessment must be laid at the door of the respondent, leaving only [Ms. D]'s failure to attend the April 18, 2017 as her only failure.**

[12] Following the accident on November 24, 2015, [Ms. D] was assessed several times. On December 15, 2015, Sasha Stewart, OT, assessed her attendant care needs at $8,262.22 per month. On receipt of that assessment the respondent arranged for [Ms. D] to be assessed by its OT, Ranu Singh. In a report dated March 2, 2016, Ms. Singh found [Ms. D] required $1,123 per month in attendant care services. Ms. Stewart conducted a second assessment and, in her report dated April 5, 2016, again found [Ms. D] required $8,262.22 per month in attendant care. Following a second assessment on September 7, 2016, Ms. Singh found [Ms. D] needed $774.29 per month.

[13] Approximately four months later, on January 25, 2017, Ms. Stewart found that [Ms. D] required $3,930.74 in attendant care. This last Stewart report stimulated the respondent to require [Ms. D] to undergo a further assessment with Ms. Ranu. **By letter dated March 30, 2017, enclosing the Notice of Examination, the respondent informed [Ms. D] that the appointment was scheduled for April 18, 2017. [Ms. D]'s counsel replied on April 6 informing the respondent that the Notice of Examination failed to give adequate medical and any other reasons. No other grounds were alleged although subsequently there have been allegations against Ms. Singh that her previous assessment had resulted in [Ms. D] sustaining a hernia.** Those allegations have proceeded to litigation, but at this time they are only allegations and I have not considered them in arriving at my conclusions.

[16] In the current case, the respondent identified the benefit in dispute since a Form 1 denotes an attendant care benefit. It stated that the recent Form 1 was in an amount triple the amount found by its assessors and noted that this increase is inconsistent with recent medical records showing overall improvement. It identifies the section in question, s. 44. I find that the reasons set out are sufficient to permit [Ms. D] to make an informed decision whether to attend the assessment or abandon her claim. She certainly did not abandon her claim as she filed her appeal with the Tribunal several days after her non-attendance.

[17] [Ms. D]'s failure to attend the April 18, 2017 IE triggers the provisions of s. 55. It remains for me to consider the exercise of my discretion.

Discretion under ss. 55(2) and (3)

[18] **On the facts before me, I find that [Ms. D] failed to attend one IE in April 2017**. While in and of itself, in the right circumstances, this failure might be sufficient to strike her claim, she has advanced her claim vigorously, has now been determined to be catastrophically impaired, and has stated a willingness to attend rescheduled IEs. In my view, it would be unjust in these circumstances to strike her claim at this point.

[19] I am cognizant of the fact that her application has now been before the Tribunal for in excess of five years and must be moved along to resolution. For this reason, I am not prepared to order a stay of her application until she attends. Such an order is too vague and open to further slippage of time. Instead, the preferable course is for the parties to take immediate steps to have the IEs completed and the matter set down for a hearing. To bring this outcome about, I will set a timetable.

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Moore v. Jacob, 2022 ONSC 10 (CanLII), <https://canlii.ca/t/jlk0r

[37] The next condition demanded by counsel for the plaintiff was that the expert report be drafted solely and entirely by the examining assessor, and that the research, medical record review and drafting of the report be conducted solely and entirely by the assessor. In short, the plaintiff wanted to preclude "ghostwriting".

[38] Rule 33.06(1) governs the contents of an expert's report. It provides as follows:

33.06 (1) After conducting an examination, the examining health practitioner shall prepare a written report setting out his or her observations, the results of any tests made and his or her conclusions, diagnosis and prognosis and shall forthwith provide the report to the party who obtained the order.

[39] This rule has been interpreted to preclude ghostwriting, where the report is written partly by others: see *Kushnir v. Macari*, 2017 ONSC 307 at para. 38. To demand of defendants' counsel that ghostwriting not be used is tantamount to demanding that they comply with the Rules. Such a condition is unnecessary, and I decline to order it.

[40] The final issue to be resolved relates to the cancellation fee. **The plaintiff points out that the appointment with Dr. Mitchell was set up by defendants' counsel without securing the consent of the plaintiff**. The plaintiff relies on *Armocida v. Sanelli*, 2003 CanLII 34705 (ON SC), [2003] O.J. No. 3199 (S.C.J.), which stands for the proposition that unless there is a court order for an IME, or the written consent of the plaintiff, the plaintiff cannot be held liable for the cancellation fee in the event of his or her non-attendance. Master Dash said the following, at paras. 12-13:

A defendant in a tort action can only compel a plaintiff to attend a defence medical examination by virtue of section 105 of the *Courts of Justice Act* and Rule 33. **To compel payment of cancellation fees from the plaintiffs, or to enforce other penalties for example under rule 33.07, the examination must be properly constituted under those provisions.** There are two methods provided thereunder for compelling attendance. The first method is by court order. Under section 105 where the physical or mental condition of a party is in question the court "may order" one or more examinations by health practitioners. In this case the defendants chose to fix a date for examination without court order.

A second method of compelling attendance at a defence medical examination is under rule 33.08 which provides that Rule 33 applies to a physical or mental examination "conducted on the consent in writing of the parties." There is good reason for requiring the consent in writing. This provides the parties, and the courts in the event of non-compliance, with proof that the plaintiffs had agreed that their health was in issue in the action, had agreed to an examination by the specific doctor, had agreed to the specific date and had agreed that it would be an examination equivalent to an examination ordered under Rule 33. In this case the defendants did not obtain the plaintiffs' "written consent" to the examination. They did not even consult in advance with plaintiffs' counsel. They chose instead to unilaterally set up an examination and fix a date. By doing so they ran the risk that if the plaintiffs failed to attend they would have no recourse. Although they did ask plaintiffs' counsel to confirm in writing that the plaintiffs would be attending the examinations such written consent was never forthcoming. Although there is some evidence that an assistant of Mr. Suboch confirmed by telephone to the assistant of Mr. McCarthy that the plaintiffs would attend, this is not the written consent required by the rule. In the result in my view there is no authority to order payment of Dr. Ameis' cancellation fee and I decline to do so.

[41] The defendants did not address this issue in their factum, nor in oral argument. I agree with the comments of Master Dash, and **decline to order the plaintiff to pay the cancellation fee**.

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Lipovetsky v. Sun Life Assurance Company of Canada, 2018 ONSC 1664 (CanLII), <https://canlii.ca/t/hqxs0

Claim for costs thrown away

[15] **On 10 January 2018 the defendant booked the IME with Dr. Bentley for January 31. On January 30 the plaintiff advised that she would not attend. Cancellations costs were incurred for Dr. Bentley ($1,875) and for the arranged transportation ($42.50) as a result. Additionally, defence counsel submitted its time printout showing it incurred costs of approximately $2,800 to negotiate and organize the IMEs. It seeks costs thrown away of $4,719.45.**

[16] **The plaintiff takes the position that the defendant was premature in booking the IME with Dr. Bentley as the parties had not agreed on terms.**

[17] It argues that the plaintiff was aware well in advance of January 30 that the plaintiff would not attend unless there was an agreement on terms. On 4 January 2018 defence counsel requested the plaintiff's availability for January 31 for the appointment with Dr. Bentley. On 5 January 2018 plaintiff's counsel confirmed his client's availability and stated that the

plaintiff may wish to record the examination. "Please advise whether that poses an issue." On 8 January 2018 defence counsel confirmed that this was an examination under the Rules and advised that the plaintiff would need to obtain the consent of the doctors to any recording. On 9 January 2018 plaintiff's counsel advised that the defendant should advise the doctors of her intention and noted that his client would not sign any consents that he had not seen in advance. On 10 January 2018 defence counsel advised plaintiff's counsel that he disagreed with the plaintiff's view on the right to record an examination absent a court order. **With known disagreement on the audio recording, defence counsel proceeded to book the IME with Dr. Bentley on January 10.**

[18] On 14 January 2018 plaintiff's counsel advised that his client intended to bring a companion to the IME with her. On 18 January 2018 defence counsel wrote that he would advise the doctor of this intention but that it would be up to the doctor whether that would be allowed. That same day defence counsel sent the forms of consents from the doctors. On 22 January 2018 plaintiff's counsel revised the forms to delete the prohibitions on the attendance of a companion and on recording the examination.

[19] **It was clear on 10 January 2018 when the IME was booked that the parties did not agree on the terms under which it would be conducted. If it was not clear then, it was clear by 22 January 2018 that there were fundamental disagreements. There is no evidence before me on the cancellation terms of Dr. Bentley but it would have been prudent either to not book the IME until the terms were sorted out or to cancel by January 22.**

[20] I do not fault the defendant for attempting to move this matter along by securing IME dates. **However, it turned out to be premature to book the examination without an agreement on terms and I will not order the plaintiff to pay the attendant cancellation costs.**

Miscellaneous

[21] There was evidence in the record of consent forms that where required by either Dr. Siu or Dr. Bentley that contained terms outlining at least what Dr. Siu saw his professional obligation and to which he required the plaintiff's consent. While the plaintiff viewed those forms as consents, what they are are acknowledgements of the limitations on confidentiality in the circumstances of the examination. For instance, one term particularly troubling to the plaintiff was that Dr. Siu could certify and admit the plaintiff to hospital against her will for psychiatric treatment if he felt she was a danger to herself. The plaintiff is not prepared to sign such a form as a condition of the defendant's chosen doctor conducting an IME.

[22] As cited in *Tanguay v. Brouse* (2002) 20 C.P.C. (5th) 376 (S.C.J.):

In *Bellamy v. Johnson*, the court made the distinction in roles between that of a doctor conducting a defence medical assessment under s. 105 of the *Courts of Justice Act* and a doctor examining a patient within the bounds of the traditional doctor-patient relationship. That distinction lies at the core of this decision. In my view, a medical examination conducted under s. 105 of the *Courts of Justice Act* and Rule 33 enables a health practitioner in Ontario to (a) carry out the examination and (b) report his/her findings to the adversary of the party examined without fear of successful prosecution for professional misconduct based on the absence of written consent to do either or both of (a) and (b).

[23] I adopt the *dicta* of Valin, J. in *Tanguay,* as follows:

I am of the view that s. 105 of the *Courts of Justice Act* and Rule 33 contain a complete code and procedure for court ordered medical examinations in Ontario. **Neither s. 105 of the *Act* nor Rule 33 contain a requirement that the party being examined execute any consent, authorization or agreement presented by an examining health practitioner in advance of or during an examination.**

[24] I hold that the plaintiff is not required to sign a release, consent or agreement as a condition of undergoing the IMEs.

[25] Lastly, counsel for the plaintiff asked me to make an order prohibiting the doctors conducting the IMEs from speaking to defence counsel. I am not prepared to make such an order. As noted in *Moore v. Getahun* 2015 ONCA 55, consultation between counsel and expert witnesses in preparing reports is necessary to ensure the efficient and orderly presentation of expert evidence and timely, affordable and just resolution of claims.

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Rintjema v. TD Home and Auto Insurance Company, 2018 ONSC 996 (CanLII), <https://canlii.ca/t/hqd9r

[14] In response to the Form 1, the defendant requested a second examination by Dr. Tuff and a defence In-Home Occupational Therapy Assessment. The defendant suggested June 7, 2017 and June 14, 2017, respectively, for the further defence medicals. A request was made for three days' notice of any cancellation. The defendant had retained an assessment company, Direct IME, to arrange the further examinations.

[15] On May 31, 2017, Mr. O'Brien communicated to the defendant that he saw no need for a second neuro-psychological examination but his client would attend with the occupational therapist ("O.T."). On June 7, 2017 Mr. Woodward agreed to proceed with the O.T. examination only and have Dr. Tuff do a paper review if necessary.

[16] **At that point, there was an unfortunate turn of events. The refusal to attend with Dr. Tuff was never communicated by the defendant to Direct IME. A transit service attended the assisted care home where the plaintiff resided and loaded him up and off to Hamilton without advising anyone.**

[17] Once in Hamilton, Dr. Tuff commenced his assessment relying on his apparent view that the plaintiff could consent despite his prior contact with the litigation guardian and his knowledge of the plaintiff's disability.

[18] The plaintiff was then loaded back up and returned to Chatham having spent an entire day with nothing to eat but a bag of chips. As would be apparent, the plaintiff was upset, Ms. Rintjema and Mr. O'Brien were incensed.

[19] Mr. O'Brien demanded an explanation as to how this could have happened. When he did not receive the information he requested he obtained an order from Justice Raikes to examine Dr. Tuff and Susan Brown, an IME co-ordinator at Direct IME, as witnesses on a motion (Rule 39.03).

[20] **The examination of Dr. Tuff revealed that he had planned an assessment taking 5-7 hours but terminated it early as he was concerned about a lack of consent. Dr. Tuff was unable to advise the reason for his concern despite having earlier suggested that he had received informed consent from the plaintiff himself.** Dr. Tuff stated that he had not

scored his assessment but felt the result and his opinion would not likely vary from his earlier position. He had not prepared a report and had deleted all his electronic files related to this assessment in the same month he was served with the Summons to a Witness on a motion.

[21] In both his evidence, and in the documents produced by the defendant, Dr. Tuff identified an assistant named Dr. Bird who was actively involved in the assessment and communicated directly with Direct IME about the plaintiff. Dr. Bird is in fact a former practicing psychologist who, in 1994, had his license revoked for abusing a patient by entering into an intimate relationship. It seems Dr. Tuff, the practitioner conducting the examination, does not agree with all the conclusions provided to Direct IME by Dr. Bird.

[31] **The conduct of the defendant and its agent Direct IME was inept in the extreme. Particular care should have been taken with their vulnerable insured if they were requiring further examinations. Having said that, I cannot conclude that their actions were nefarious or taken to obtain an upper hand in the litigation.** The reaction of the plaintiff, his litigation guardian and his counsel, while understandable, cannot determine the right to the O.T. assessment.