



# Accident Benefit REPORTER

## Customized Insurance

The Liberal Government has recently announced that, as part of their commitment to improve the automobile insurance product for Ontario motorists, it is considering implementation of a “customized” auto insurance policy.

Such a policy would continue to require motorists to carry a standard package of coverage which would include:

- i) minimum limits for liability coverage (currently \$200,000.00),
- ii) the same coverage for compensation for repairs to an owner’s own automobile (when the accident is not the owner’s fault)
- iii) protection for oneself and one’s family in the case of being hit by an uninsured automobile
- iv) a minimum level of standard accident benefits coverage, including medical and rehabilitation benefits, attendant care benefits, case manager services in catastrophic injury cases, funeral benefits and transportation expenses.

The portion of the proposed “customized” policy which would be optional and which could be tailored to meet one’s needs, would take the form of “Buy-Up” or “Buy-Down” packages of coverage, which would be added to the standard automobile insurance policy or declined.

The Proposed Buy-Down Benefits, which would be packaged in bundles include:

- i) **No Income Replacement Bundle** - Insured would decline coverage for income replacement benefits and the lump sum death benefit
- ii) **No Dependants Bundle** - Insured would decline coverage for the Caregiver benefit and Lost Educational Expenses
- iii) **No Minor Losses Bundle** - Insured would decline coverage for Housekeeping & Home Maintenance Expenses, Visitors Expenses, and Damaged Clothing/Glasses/Hearing Aids etc.

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## New at TR...

Veronica Rossos and  
Adrienne Kirsh  
have recently joined the firm  
as Associates in the  
Personal Injury Group.



Veronica Rossos



Adrienne Kirsh

The **Proposed Buy-Up Benefits**, which would also be packaged in bundles include:

- i) Optional Income Replacement Benefits
- ii) Optional Caregiver and Dependant Care Benefits
- iii) Optional Medical, Rehabilitation and Attendant Care Benefit
- iv) Optional Death and Funeral Benefit

The Liberal Government states that the Customized Insurance Policy would result in motorists being able to reduce their automobile insurance premiums, by allowing motorists to “customize” their insurance to their needs. While at first blush such a proposal seems enticing, there are a number of difficulties.

Many years ago the Kruger Commission considered whether a customized automobile insurance policy was a viable option for the motoring public, and concluded that such a policy was not good for the consumer for a number of reasons:

- i) Most people will simply opt for the cheapest coverage they can purchase. They will not properly understand what they are giving up by declining some of the customized coverage. Most people will not appreciate what they have given up, until they have been in an accident and need the benefits, only to find that they do not have them.
- ii) When people decline the optional coverage, they may find that they do not have enough money to pay for necessary medical/rehabilitation expenses or attendant care. Injured parties may then have to resort to OHIP funded treatment. With the recent cutbacks in OHIP coverage, and possibly more to come in the future, injured motorists may be left with few options for treatment or care after the standard benefits are exhausted.
- iii) Proponents of a customized policy recognize that even if such a system was to be introduced, significant public education regarding the options would be necessary. This would require each motorist to sit down with their insurance broker or agent, to carefully determine exactly what type of coverage they require. Experience has shown that despite the fact that there are some optional coverages available under the existing standard automobile policy, most motorists have no idea what those optional coverages are, and most have never received a proper explanation of the optional coverages which are currently available to them.
- iv) Insurers or insurance brokers cannot always be relied upon to adequately educate the public about their rights. Under the current legislation it is clear that most motorists are not aware of their rights under this complex system. This promises to get worse with these proposed changes.
- v) There is no proof that a customized automobile insurance policy will lead to lower insurance premiums for the average motorist. Those motorists who are most likely to have private insurance coverage for the type of “optional” benefits proposed, already have such a policy in place. In the event of an accident, those with private coverage are forced to resort to their private coverage first, before they are entitled to any benefits under the automobile insurance policy. Under our current system those motorists with private coverage are, in essence, partially subsidizing the cost of auto insurance for those who do not have private coverage. Under a customized system, those motorists with private coverage will decline the optional coverage, and the cost of this “optional coverage” will be borne exclusively by those who opt for the “optional coverage”. As a result, the optional coverage will likely be expensive, and the average motorist (without private coverage), may actually find that their premiums will increase for the same coverage they have under their current automobile policy.



*Leonard Kunka,  
Partner*



*Leonard Kunka, Partner*

# Expert Assessor Network: Gone But Not Forgotten

As many of you will recall, in the weeks and days leading up to the October 3, 2003 provincial election, Dalton McGuinty and his provincial Liberals promised to make fundamental changes to the delivery of medical and rehabilitation benefits as part of a larger plan to change the face of automobile insurance in Ontario. In particular, during their campaign the Liberals promised to abolish all Designated Assessment Centres (DACs) stating that DACs were too expensive, too cumbersome and failed to respond to the needs of accident victims. After October 3, 2003, the public waited and wondered whether the Liberals' proposal to bring an end to the DAC system was an empty promise.



Michael Bennett

## The White Paper

On March 19, 2004, the Honourable Mike Colle, Parliamentary Assistant to the Minister of Finance and the man in charge of reforming Ontario's auto insurance system, released a White Paper entitled "Expert Assessor Network: Proposed Model to Replace the Designated Assessment Centre System". According to this White Paper, the Liberals proposed to abolish the DAC system altogether and in its place, implement a new system which would not only replace the DAC system but also abolish the need for section 24 evaluations (Evaluations initiated by an automobile accident victim) and section 42 evaluations (Insurer Evaluations) which would result in a huge cost savings for all Ontario drivers.

## What is the Expert Assessor Network?

The Expert Assessor Network system involved a network of local doctors who would receive auto accident injury cases referred to them by the Financial Services Commission of Ontario (FSCO). The Network would include a pool of, for the most part, family physicians, who, within 5 days of a referral would assess, diagnose and propose a rehabilitation plan for the accident victim with a report to follow 5 days later. If the physician required input from additional health professionals, a specialist would be drawn from a second pool of assessors and would be obliged to conduct the second assessment within an additional 5 days.

## What Went Wrong

After the release of the White Paper, numerous critical comments were received by the provincial

Liberals questioning their ability to implement what seemed on its face to be a fair and rational scheme. As it is with most things related to Statutory Accident Benefits, the devils were in the details. The most scathing response to the White Paper came from the Association of Designated Assessment Centres who concluded that the Expert Assessor Network is a completely unworkable scheme. According to the Association of Designated Assessment Centres, the Expert Assessor Network would never work in Ontario for the following reasons:

- The Expert Assessor Network is contingent upon finding a pool of independent physicians in general practice when there are already too few of these doctors in Ontario.
- Physicians in general practice are not always the health professionals most suitable to make treatment recommendations in light of the injuries commonly sustained by automobile accident victims.



- It was impractical to believe that both insurers and insured persons would find the Expert Assessor Network's pool of physicians neutral which would ultimately lead to costly insurance disputes.
- The proposed system would likely lead to health professionals assuming the role of claims manager which is unfair to the physicians and a wasteful use of resources.
- The Expert Assessor Network system provided no appeal mechanism for what was intended to be binding assessments.
- The system creates a physician-centric model of assessment which was inconsistent with the community-based healthcare approach recommended in the Romanow Report.
- Elimination of all section 24 assessments is unfair, unmanageable and would likely lead to enormous disputes.

## Back to the Drawing Board

As a result of the numerous and thoughtful critiques received through the consultation process, Arthur Lofsky, Special Assistant to Michael Colle, stated that the Liberal government would be going back to the drawing board to find a new system to replace the current DAC system as the Liberals had promised. According to Mr. Lofsky, "we listened, and we heard some problems [with the proposal] and we're going to fix them."

Insiders in the insurance industry believe that the Liberal government is working on a new proposal to replace both the current DAC and insurer evaluation systems. From all accounts, the Liberals seem committed to reducing the expense and duplication of the existing model. The Statement of Priorities currently found on the Financial Services Commission of Ontario website states that FSCO and the Liberal government remain committed to replacing the Designated Assessment Centre system with a new assessment process. According to the Statement of Priorities, "monitoring and evaluation will be a key component for the new system to be launched in 2004-05".

*Michael Bennett*

# Auto Insurance Reform Needed More Than Ever

**I**n the wake of a significant increase in insurance industry profits, insurance reform is needed more than ever. Easing the pressure on premiums should not be taken as a signal that all is well in auto insurance. Rather, it is the opportunity to address other important areas in need of reform.

For many years the insurance industry argued that poor returns justified significant reductions in the rights of accident victims to compensation in order to keep the industry viable. The threat of dramatically increased premiums and the potential withdrawal of some insurers from underwriting auto insurance prompted political panic. It was widely perceived that the New Brunswick Conservative government nearly lost an election over the issue of high car insurance premiums. This sent the Liberal and Conservative parties in Ontario scrambling for ways to address the perceived problems with auto insurance in the months leading up to the October 2003 election. Under pressure from the insurance industry for a quick fix, and fearing the political fallout, the political parties opted for changes that further reduced the rights and entitlement of accident victims.





*Richard Halpern,  
Partner*

The changes put forward by both parties sought savings largely at the expense of accident victims rather than by addressing other important contributing factors to the expense of auto insurance. Given the vigour with which the insurance industry cried “poor”, it came as quite a surprise when it was recently announced that insurance company profits rose almost 800% in 2003. That is 2.6 billion dollars in profit for 2003. In the first 6 months of this year federally regulated insurers earned a significant profit of \$1.7 billion. Just this month the Toronto Star reported that if this trend continues for the balance of the year the industry will see an incredible 17% return on shareholder equity.

Incredibly, the insurance industry is trying to attribute some of this dramatic increase in profitability to increased gas prices. Moreover, the spin being put on these changes by the industry tends to take the focus away from the impact of diminished rights for accident victims as a significant contributing factor.

The apparent change in insurance company profits (something that was undoubtedly expected long before it was announced and when the industry was predicting gloom and doom) may be seen as good news to some. To accident victims, however, there is no consolation. The changes detrimental to their interests are already in force. Our government sees the insurance industry response to it’s sudden change in fortune as the opportunity to come through with reduced premiums. This will undoubtedly allow the McGuinty government to deliver on an election promise of reduced premiums. But there are further significant savings to be had that will allow for lower premiums and a return of some of the rights unjustly taken away from innocent accident victims. Auto insurance is no longer a hot political issue and therefore the will to address other very significant problems in the industry may be lost.

It might be reasonable to conclude, based on the recent good fortune of the insurance industry, that they were merely “crying wolf”. At a minimum, the recent draconian changes which came into effect on October 1, 2003 should be undone. However, more is needed and pressure needs to be kept up to address the systemic problems that take away compensation from accident victims. Reducing waste, fraud and expenses while at the same time reconsidering the level of no fault accident benefits will help achieve the restoration of fairness to innocent accident victims at the same time as allowing affordable insurance and a viable insurance industry.

The focus should not be solely on premiums, though affordability is vital. Rather, the attention must be on the product and the system in which it operates. Changes need to be made with respect to tort claims and accident benefits compensation. A reduction in expense associated with accident benefits will go a long way to restoring resources needed to provide fair and adequate compensation in tort.

The Accident Benefits schedule is unduly complex and expensive to administer. Each amendment to the regulations has succeeded in adding further layers of complexity which in turn add further expense. Most accident victims are incapable of understanding the system or negotiating their way through it. More personnel are required with each successive change. There are more forms to be filled out; more adjusters hired to handle the claims; more health care professionals to evaluate the claims; more office space and rent to be paid. The bureaucracy has grown out of control and consequently so too has the cost. This in effect diverts huge sums that might otherwise be available to provide fair compensation to innocent accident victims.

Premiums will be kept under control only with continued reforms to auto insurance. The other side of the equation is fairness and equity for victims of accidents. To balance both, we need to fix the problems now. With insurers profitable and premiums under control, insurance reform will not be an important issue for our provincial government. We need to convince them otherwise.

*Richard Halpern, Partner*

# Comparison of Key Changes to Accident

<b>Bill 59</b> (Nov. 1, 1996 to Sept. 30, 2003)		<b>Bill 198</b> (Oct. 1, 2003 to present)
<b>Accident Benefits</b>		
<b>Important Time Limits</b>	Notice to the accident benefits insurer within 30 days of the accident.	Notice to the accident benefits insurer within 7 days of the accident. (Where notice received after 7 days, insurer may delay determining benefits entitlement for up to 45 days after notice received.) An application for accident benefits must be submitted within 30 days of receipt of application forms from the insurance company. Many other time limits from SABS that is applicable to our Health Care Professionals i.e. re: Assessment Plan, Tx Plan, DAC.
<b>Examinations under Oath</b>	N/A	Insured person may be examined by insurer under oath.
<b>Definition of "Catastrophic Injury"</b>	<p>Catastrophic Injury includes:</p> <ul style="list-style-type: none"> <li>• paraplegia or quadriplegia;</li> <li>• Amputation or other impairment causing the total and permanent loss of use of both arms;</li> <li>• Amputation or other impairment causing the total and permanent loss of use of both an arm and a leg;</li> <li>• Total loss of vision in both eyes;</li> <li>• Brain impairment that, in respect of an accident, results in,               <ul style="list-style-type: none"> <li>i. a score of 9 or less on the Glasgow Coma Scale, as published in Jennett, B. and Teasdale, G., Management of Head Injuries, Contemporary Neurology Series, Volume 20, F.A. Davis Company, Philadelphia, 1981, according to a test administered within a reasonable period of time after the accident by a person trained for that purpose, or;</li> <li>ii. a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale, as published in Jennett, B. and Bond, M., Assessment of Outcome After Severe Brain Damage, Lancet i:480, 1975, according to a test administered more than six months after the accident by a person trained for that purpose;</li> </ul> </li> <li>• Subject to subsection (2) and (3), any impairment or combination of impairments that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in 55 per cent or more impairment of the whole person, or</li> <li>• Subject to subsection (2) and (3), any impairment or combination of impairments that, in accordance with the American Medical Association's <i>Guides to the Evaluation of Permanent Impairment</i>, 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder; ("deficiency invalidante")</li> </ul> <p>N/A</p> <p>N/A</p>	<p>Catastrophic Injury includes:</p> <ul style="list-style-type: none"> <li>• paraplegia or quadriplegia;</li> <li>• Amputation or other impairment causing the total and permanent loss of use of both arms or both legs;</li> <li>• Amputation or other impairment causing the total and permanent loss of use of one or both arms and one or both legs;</li> <li>• Total loss of vision in both eyes;</li> <li>• Brain impairment that, in respect of an accident, results in,               <ul style="list-style-type: none"> <li>Same</li> <li>Same</li> <li>Same</li> <li>Same</li> </ul> </li> </ul> <ul style="list-style-type: none"> <li>• (1.3) Subsection (1.4) applies if an insured person is under the age of 16 years at the time of the accident and none of the Glasgow Coma Scale, the Glasgow Outcome Scale or the American Medical Association's <i>Guides to the Evaluation of Permanent Impairment</i>, 4th edition, 1993, referred to in clause (1.2) (e), (f) or (g) can be applied by reason of the age of the insured person. O. Reg. 281/03, s.1 (5)</li> <li>• (1.4) For the purposes of clauses (1.2) (e), (f) and (g), an impairment sustained in an accident by an insured person described in subsection (1.3) that can reasonably be believed to be a catastrophic impairment shall be deemed to be the impairment that is most analogous to the impairment referred to in clause (1.2) (e), (f) or (g), after taking into consideration the developmental implications of the impairment. O.Reg. 281/03, s. 1(5).</li> </ul>

# Benefits from Bill 59 to Bill 198

<b>Bill 59</b> (Nov. 1, 1996 to Sept. 30, 2003)		<b>Bill 198</b> (Oct. 1, 2003 to present)
<b>Accident Benefits</b>		
<b>Examinations and Assessments</b>	Insurer to pay all reasonable expenses incurred by or on behalf of insured person for the purposes of attending an examination or assessment.	<p>Insurer not required to pay for an assessment unless it is reasonably required and the insurer approves the assessment. Approval is obtained by way of Application for Approval of an Assessment or Examination (OCF-22). Approval must be obtained prior to assessment except first three assessments to complete a Treatment Plan do not require prior approval if assessments cost \$180 or less, where there is one assessment/provider. Also, prior approval is not required where immediate risk of harm to the individual makes obtaining prior approval impractical, or for completing a Form 1or for assessment for a determination of catastrophic impairment while insured is in hospital.</p> <p>Where prior approval is sought, the insurer must respond to the Assessment Plan in two business days, if the cost is \$180 or less, and within five business days where the cost is more than \$180. If approval is required and not sought, the insurer is not required to pay and there is no right of dispute. If approval is sought and denied, the request for assessment goes to a DAC.</p>
<b>Pre-Approved Framework Guidelines</b>	N/A	Pre-approved treatment framework (PAF) developed for modest injuries defined as WAD I and WAD II injuries. Insured person must be assessed within 21 days following accident. Treatment plans not required unless requesting additional goods and services
<b>Fast Track DACs</b>	N/A	If a designated assessment is conducted to determine whether there are medical or rehabilitation benefits payable other than under a PAF or the designated assessment is required because the insurer has denied all or part of an OCF-22 application (as discussed above), the DAC shall deliver its report within five days. (See Fast Track DAC intake protocol set out in the Medical and Rehabilitation Designated Assessment Centre's DAC Assessment Manual – August 2003.)
<b>DAC Referral Process</b>	Individuals assessed by closest qualified DAC.	Insurers can suggest DAC. If individual does not agree, Financial Services Commission appoints DAC.
<b>Treatment Plans</b>	Required for insurer approval of treatment	<p>Required for insurer approval of treatment (goods and services)</p> <p>Not required for claimants in the PAF (unless request for additional goods and services not covered by PAF)</p>
		<p>Obligations on the Health Professional responsible for preparing and supervising the Treatment Plan:</p> <ul style="list-style-type: none"> <li>- Secure a consent form signed by the claimant (OCF 5)</li> <li>- Include all goods and services contemplated by the health professional/facility</li> <li>- Ensure that there is no other coverage available or identify other coverage</li> <li>- Plan must be certified by Health Practitioner as reasonable and necessary – Occupational Therapists, Nurse Practitioners and Speech-Language Pathologists are now included as “Health Practitioners” and can sign off on Treatment Plans</li> <li>- Greater obligations to describe injury, sequelae and other relevant health history</li> <li>- Explain consequences of releasing health information</li> <li>- Incurred expenses are payable after 14 days if the insurer has not responded to the Treatment Plan</li> <li>- Treatment Plan can also be used to obtain insurer approval for payment of assessments</li> <li>- If the treatment Plan is denied – DAC within 5 days after selection of DAC (Insurer selects the DAC, if insured disagrees, F.S.C.O. selects the DAC)</li> </ul>

NOTE: A summary to changes to TORT from *Bill 59* to *Bill 198* will appear in the next issue of the Accident Benefit Reporter.

# Current Issues in Catastrophic Impairment Determination

Since November 1st, 1996 injured persons, their families, health care professionals, lawyers, arbitrators and courts have had to grapple with the appropriate interpretation and application of the term “catastrophic impairment”. DACs, arbitrators and Judges have considered issues relating to catastrophic impairment including the GCS and the impact of intubation, alcohol, medication and other extraneous factors.

*Bill 198* implemented changes to both the definition of catastrophic impairment and the process for determination of catastrophic impairment. The elements of the catastrophic impairment definition will not be repeated here. However, you may refer to the chart which outlines the changes under *Bill 198* on pages 6 and 7 of this newsletter.

## Changes affecting persons under age sixteen (16)

The most significant changes to the definition implemented by *Bill 198* concerns the method of applying the entitlement tests to children. SABS Sub-sections 1.4 and 1.3 contain the elements of the change.

The *Bill 198* SABS Sub-section 1.4 reads:

*(1.4) “for the purposes of clauses (1.2) (e), (f) and (g), an impairment sustained in an accident by an insured person described in Sub-section (1.3) that can reasonably be believed to be a catastrophic impairment shall be deemed to be the impairment that is most analogous to the impairment referred to in clause (1.2) (e), (f) or (g), after taking into consideration the developmental implications of the impairment.” O. Reg. 281\03, s.1 (5)*

In essence, this change allows for the expansion of the catastrophic criteria as it relates to injured persons under 16 years who are being evaluated under the GCS, GOS, and/or AMA Guides impairment testing criteria.

Paraphrasing Section 1.4, if the assessing practitioner finds that none of the GCS, GOS, or AMA Guides testing criteria can be applied because of the age of the person, then the practitioner should consider the developmental implications of the impairment and use his/her clinical judgment to indicate whether the injured person can reasonably be believed to be catastrophically impaired. If the assessor reaches the conclusion that the injured person is catastrophically impaired, Section 1.4 deems the person to be catastrophically impaired under either the GCS, GOS or AMA Guides, whichever is most analogous.

This SABS amendment increases the opportunity for use of and reliance upon clinical judgment in determining entitlement. Directives supporting the use of clinical judgment in testing are familiar to *Bill 59*, the AMA Guides and the CAT DAC Guidelines.

For instance, Section 2 of the AMA Guides (page 8) provides that:

*“If in spite of an observation or test result, the medical evidence does not appear to be of sufficient weight to verify that an impairment of a certain magnitude exists, the physician should modify the impairment estimates accordingly, describing the modification and explaining the reason in writing”.*

In addition, the Catastrophic DAC Guidelines of April, 2002, require assessors to rely upon clinical judgment at numerous points during the assessment process. For instance, the introduction portion of the CAT DAC Guidelines provides:

*“Although CAT DAC processes must conform to the SABS and the requirements of this guide, it is the responsibility of each clinician involved in the assessment to use his/her own clinical judgment in planning the assessment and interpreting the assessment outcome in our opinion”.*



David MacDonald  
Partner

Further, in Section 1.5 of the Guidelines:

*“This Guide will not provide interpretation of any SABS terminology, including the definition of catastrophic impairment. It is the responsibility of the CAT DAC assessor(s) to use his/her own clinical judgment in arriving at conclusions and to support these conclusions in a well-documented report.”*

Also at Section 4.2:

*“Interpretation of Catastrophic Impairment definitions (a) to (d) will not be provided in this Guide, as generally accepted interpretation exists. Clinicians should use their own clinical judgment and experience in establishing a claimant’s classification into one or more of the (a) to (d) categories.”*

Last, under Section 4.7 - Pediatric Catastrophic Impairment Assessment Process, the April 2002 Guidelines indicate:

*“Specific assessment protocols mandated in the SABS may not always be applicable to a pediatric population, specifically the GCS, GOS and the AMA’s Guides. . . it is the responsibility of each clinician involved in the assessment to use his/her own clinical judgment in planning the assessment and interpreting the assessment outcomes. CAT DACs should conclude that a child meets the definition for catastrophic impairment if, in their opinion, any of the SABS (a) to (g) criteria are analogous to the impairment sustained by the child.”*

The use of analogy in interpreting the AMA Guides is also incorporated into the SABS at Section 2 (3).

When an impairment sustained by an insured person not listed in the AMA Guides:

*“It shall be deemed to be the impairment that is listed in that document that is most analogous to the impairment sustained.”*

## **Timing of the CAT DAC**

Under *Bill 59*, one could not use the AMA Guides to evaluate the catastrophic impairment unless (a) the person’s condition had “stabilized and was unlikely to improve with treatment”, or (b) three years had elapsed since the accident.

Under *Bill 198*, the AMA Guides may be used to evaluate catastrophic impairments so long as the insured person’s health practitioner states in writing that (a) the insured person’s “condition is unlikely to cease to be catastrophic”, or (b) two years have elapsed since the accident.

## **Effect of Alcohol on GCS**

In June, 2004 *Holland v. Pilot Insurance Company* was decided. In that case, Justice Keenan had to determine whether a 15 year old boy with GCS readings of 7/15, 8/15 and 4/15 should be denied catastrophic impairment status because he was known to have consumed alcohol so that his blood alcohol level was above the legal limit and because he had probably smoked marijuana. The CAT DAC had set aside the GCS scores as “confounded”. The Defendant, Pilot argued that the GCS scores should not be considered and had been set aside by the CAT DAC because the “presence of alcohol would make the GCS reading unreliable.”

Justice Keenan rejected this argument and the CAT DAC’s approach and found that the DAC misread the legislation by trying to impose limitations on the reliability of the GCS when those limitations were not clearly set out in the legislation itself. He accepted the GCS scores on their face and found the Plaintiff catastrophically impaired using the GCS criteria. In doing so he echoed the comments of the Ontario Court of Appeal in *July v. Neal*:

*“...if there is doubt in the legislation establishing and governing the cover, and there are two possible interpretations of any aspect of the cover, the one more favourable to the insured should govern.”*



## What is a Reasonable Period of Time for GCS Testing?

In the arbitral decision of *Young and Liberty*, decided November, 2003, Arbitrator Allen determined that the question of whether or not the period of time during which the person maintained a GCS score of 9 or less was a reasonable period of time “*must be determined in the context of the particular circumstances of each case*”.

In *Young* despite evidence from *Liberty* to support the conclusion that intubation, seizures and the administration of paralyzing drugs were confounding factors that would invalidate the GCS readings, Arbitrator Allen found the applicant catastrophically impaired based on 3 GCS readings taken within 1 hour of the accident.

In the unreported arbitral decision of *Unifund Assurance Company and Fletcher*, the arbitrator found that the reasonable length of time for maintenance of a GCS of 9 or less “*could be as short as 20 minutes*” in order for the injured person to have met the criteria for catastrophic impairment.

## AMA Guides – Mental and Behavioural Disorders

Catastrophic impairment designation is available to those who have been determined to have a “**marked**” impairment or an “**extreme**” impairment. Four domains are assessed to make a determination: a) limitations in activities of daily living, b) social functioning, c) concentration, and d) persistence and pace and deterioration or decompensation in work or work-like settings.

The editor of the Fifth Edition of the AMA Guides has confirmed in writing that if a person is considered to have a marked impairment in two or more of the four domains and the other domains have a less severe impairment, (eg. none, mild or moderate) then the overall impairment is classified as “**marked**” ie. Class IV.

For example, if a person’s mental and behavioural impairment levels significantly impede social functions and ability to adapt in work or work-like settings because there has been no impairment upon a person’s activities of daily living or concentration, the person is considered to have a “**marked**” impairment and should be deemed catastrophically impaired under the AMA Guides.

*David MacDonald, Partner*

*Copies of the referenced decisions and letter are available from the author on request.*

# Tort Claim and Accident Benefits Claim

**R**egular readers of the Thomson, Rogers Accident Benefit Reporter are already aware that people injured in motor vehicle accidents often have two potential claims. If someone else is wholly or partially at fault for your injuries, you may have a “tort” claim (a claim against someone at fault). Regardless of who is at fault for the accident, you may have an “accident benefit” claim (a claim under a policy of insurance). This article is intended to address some of the legislative changes under *Bill 198* that affect people who have suffered spinal cord injury as a consequence of motor vehicle trauma.





*Sloan Mandel,  
Partner*



*Wendy Moore Johns,  
Partner*

## **Tort Claim**

The single most important change under *Bill 198* is the expanded right to sue for medical, rehabilitation and care costs (“healthcare expenses”). Previously, in order to recover healthcare expenses in a tort claim, it was necessary to establish that the victim had suffered a “catastrophic impairment”. This is no longer the case. Now, *Bill 198* permits the victim to recover healthcare expenses provided she/he has suffered serious and permanent impairment to an important physical, mental or psychological function, or serious and permanent disfigurement. The effect of this change is that more innocent accident victims will be entitled to pursue a claim for healthcare expenses in tort. An accident victim with injury to the spinal cord will no longer be required to suffer from quadriplegia or paraplegia before being permitted to pursue recovery of their healthcare expenses. Now, accident victims with serious spinal cord injury (i.e. patients requiring a fusion, patients who suffer from a herniation, etc.), will receive access to very important compensation that had previously been denied.

The second most important legislative change under *Bill 198* is the amendment to the statutory deductibles. Previously, every claim for pain and suffering was subject to a \$15,000.00 deductible. Now, under *Bill 198*, the statutory deductible is increased to \$30,000.00 (bad news). However, for pain and suffering claims that are assessed at more than \$100,000.00, the statutory deductible has been entirely eliminated. Accordingly, more compensation will be paid to those persons who have suffered severe spinal cord injury.

In certain circumstances, the accident victim’s family may advance a claim for the detrimental effect that the accident has had on family relationships. Previously, there had been a \$7,500.00 statutory deduction for claims of this kind. Now, the deductible has been increased to \$15,000.00, unless the loss is greater than \$50,000.00, in which case, the deductible is eliminated.

## **Accident Benefits Claim**

In Accident Benefits claims for people who have suffered severe spinal cord trauma, the changes under *Bill 198* are generally procedural and do not affect entitlements. Victims remain entitled to enhanced benefits if they are deemed catastrophic. Conversely, if the injuries are non-catastrophic, the amount and duration of medical, rehabilitation and care benefits are greatly reduced.

In Accident Benefits claims, the most significant change for those patients who suffer non-catastrophic trauma to the spine is the streamlined approach to treat whiplash associated disorders (in particular, WAD 1 and WAD 2 injuries). For those who have suffered a WAD 1 or a WAD 2 injury, entitlement to medical and rehabilitation benefits is subject to pre-approved framework guidelines (the “PAF”). Further, entitlement to attendant care has been eliminated in the PAF. In certain circumstances, it may be possible to obtain treatment over and above that which is provided by the PAF guidelines; however, if additional treatment is sought, you will likely encounter a resistant insurer, delay and the need for advocacy.

As always, your opinions, questions and comments are welcomed.

*Sloan Mandel, Partner  
Wendy Moore Johns, Partner*



# Resolving Claims Involving Substitute Decision Makers

*I*t is rare to be presented with a client who appointed a substitute decision maker before a catastrophic accident. Usually, family members will take on the decision making role informally until they assume the responsibility of being a Litigation Guardian in a lawsuit. More recently, the Courts are requiring that a more formal relationship between decision maker and incompetent person be established as part of the settlement approval process at the end of the litigation. It is no longer acceptable to appoint immediate family members as trustees of the proceeds of the settlement to the benefit of the catastrophically injured plaintiff.

Fortunately, recent legislation has provided processes for appointing formal decision makers who are accountable to the Court on an ongoing basis. Depending on the age of the injured plaintiff, the Office of The Children's Lawyer or the Public Guardian and Trustee are involved in the process of appointing the guardians and of working out the terms of their mandates. This process needs to be carefully thought out in every case involving a catastrophically injured plaintiff, whether child or adult.

The resources of the Accident Benefits insurance policy can be used to fund an application to appoint family members as guardians of the injured person's person and/or property. As soon as it is known that the injured person is likely to be and remain incompetent of managing their own affairs, the appropriate capacity assessments and/or medical reports should be obtained to support a motion. The Accident Benefits insurer should be advised of the necessity of the appointment and of the estimated cost of the motion to appoint the guardian. That expense falls under sections 14 and 15 of the Statutory Accident Benefit Schedule. If the insurer balks at the expense, the issue can be taken to mediation and, if necessary arbitration. Usually the insurer will recognize the necessity of the appointment of someone to manage the insured person's affairs and will co-operate. This kind of motion is usually necessary only in cases that are designated catastrophic and therefore have medical rehabilitation limits of \$1,000,000.00 making the expense of the motion a relatively minor one in the context of the case.

The appointment of a substitute decision maker for an adult plaintiff invariably involves a capacity assessment and an application made on notice to the Public Guardian and Trustee. The PGT has proved to be very helpful in reviewing draft materials for these applications and in making suggestions that are helpful in avoiding problems on the return of the motion. Usually with enough discussion and co-operation prior to the motion, the PGT will usually consent to the Order appointing the guardian without attending on the return of the motion.

A problem that often arises in the case of substantial claims is how the services of a guardian can be appropriately compensated. In addition, the expense of passing accounts and of hiring accountants and sometimes institutional trustees to assist in managing the estate can be considerable. These expenses must be advanced as a claim to the accident benefits insurer as well as in any lawsuit. Proper provision should be made in the settlement to meet these ongoing and sometimes significant costs.

Often the Court will not be content with the appointment of one guardian and will require two or more in order to ensure appropriate checks and balances and orderly transition in the event of the death or departure of one trustee. In cases involving minors the Court likes to see the appointment of an institutional trustee. To date it has been extremely difficult to find trust companies or financial institutions that are prepared to act in this role without also taking on the role of managing all of the assets of the minor. This is usually not possible because many large cases are resolved



*Craig Brown,  
Partner*

with a structured settlement that produces a stream of income adequate (or nearly adequate) to meet the expenses of the minor. That leaves very little for a trust company to manage and very little opportunity for the company to charge what it considers to be reasonable fees.

Currently, there is only one institutional trustee available. However, we are negotiating with other financial institutions to take on this role at a reasonable cost to the minor. There is no solution to this problem that meets all of the requirements of the incompetent person and his or her family.

In any event, in order to receive approval for settlement involving an incompetent person, the Court must be satisfied that the guardians are capable of managing the estate; of passing accounts at appropriate intervals; of using the proceeds of the estate to the benefit of the incompetent person and finally, are likely to be able to provide these services for the reasonable life expectancy of the incompetent person.

In smaller settlements involving children, the proceeds of the settlement can be paid into Court or can be invested in a structure that will become available to the injured plaintiff when he or she attains the age of majority or later. In settlements involving very large sums of money, a decision is usually taken by the Litigation Guardian to structure the settlement – a decision which often ties up the settlement long past the date on which the injured plaintiff attains the age of majority. These decisions must be made carefully by the Litigation Guardian in consultation with the Office of The Children's Lawyer and ultimately with Court approval.

Where proceeds of the settlement need to be disbursed before the child reaches the age of majority, there are two possible alternatives. The first is to pay the money into Court and simply allow the parent to apply to the Accountant from time to time to have money paid out of Court to meet specific expenses. There is a fairly simple procedure to permit this to be done.

Where larger sums of money are needed or where there is a stream of income required, it would be necessary to appoint a family member as a guardian of the child pursuant to the *Children's Law Reform Act*. The motion for this appointment can be brought with the motion for approval of the settlement. With the formal appointment of a guardian, the Court will usually permit money to be paid out of a structure to the guardian to be used for the benefit of the child on an ongoing basis. As part of the Order it may be necessary for the guardian to pass accounts from time to time – an expense which must be contemplated in the settlement.

Where a catastrophically injured child is unlikely to become competent at the age of majority, it will be necessary to appoint a guardian under the *Children's Law Reform Act* and then bring a second motion when the child turns eighteen for the appointment of a guardian of person and property under the *Substitute Decisions Act*. The Order made by the Court when the settlement is approved will usually require that the guardian of the child arrange a competency assessment six months prior to the child's eighteenth birthday with a further requirement that, if necessary, a motion be brought to appoint a guardian of person and property.

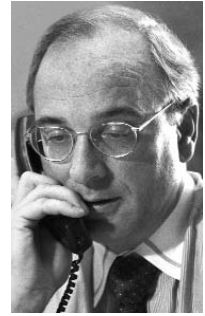
The choice of guardians is critical. The obvious choice is one or more parent, however in many cases the life expectancy of the injured child will exceed the life expectancy of the parents and arrangements should be made for a sibling or younger family member to be on standby to be appointed as a guardian or even to be appointed as a co-guardian.

In all of these complex matters, The Office of The Children's Lawyer and the Public Guardian and Trustee should be viewed as collaborators in an effort to ensure that the estate of the incompetent plaintiff is managed carefully and well for the benefit of that person. The issue of continuity and longevity of the guardians is a challenging one that needs to be reviewed carefully in any management plan if the plan is going to receive the approval of the Court under the new, much stricter criteria now being applied by Ontario judges for approval of settlements involving incompetent persons.

*Craig Brown, Partner*

# Avoid the Delay!

## Decisions under section 279(4.1) of the Insurance Act: How to obtain benefits on an urgent basis



David Payne,  
Partner

We all know of instances where an insurer will not approve benefits urgently required. There is a tendency to assume that once a requested benefit is in dispute, it will take a significant period of time to resolve, leaving accident victims without the care, treatment and benefits they urgently require. This is not the case.

Section 279(4.1) of the *Insurance Act* together with Section 65 of the Dispute Resolution Practice Code (3rd) specifically allows for urgently required benefits to be paid immediately pending a full determination of the merits at arbitration. It is possible, in certain instances, to use this process to obtain an arbitrator's order that the insurer pay the required benefits within one month of the insurer's denial.

This process can be invaluable where catastrophically injured patients are about to be discharged from hospital and no home care plan or home modifications have even been approved, let alone, completed.

Where patients suffering from an acquired brain injury are not receiving the rehabilitation therapy they desperately need post-trauma while some "dispute" drags on interminably through the normal FSCO arbitration process, a motion for interim benefits is the answer.

### How is it done?

The key to obtaining the order quickly is to communicate repeatedly with the staff at FSCO. You must still apply for mediation before even an interim order can be obtained. If you let FSCO staff know how urgent your client's needs are, it is possible to obtain a telephone mediation, pre-hearing and arbitration all within one month.

### The Test

To obtain an order that an insurer pay a disputed benefit before a full hearing on the merits has occurred, you must:

1. **Prove that there is urgency connected to the receipt of the benefits.** To satisfy these criteria, proper affidavit evidence must be obtained from qualified health care providers stating that any delay in the immediate provision of the benefits will, or could harm the person.
2. **Prove that the benefits sought are provided for in the SABS and that the treatment and cost is reasonable and necessary.** A great deal of time has been spent by the arbitrators determining if the burden of proof to satisfy the criteria above is "prima facie" or the more onerous test of "very probable". A review of the decisions suggests that the "urgency" criteria appears to govern in most instances.

### Examples of interim orders being granted

1. *Brown v. Allstate Insurance Co. of Canada* [1997] O.I.C.D. No. 144.

The arbitrator ordered the insurer to pay all equipment costs, case manager fees, attendant care fees and numerous other amounts in order that Mr. Brown, an incomplete quadriplegic, could be discharged from hospital and return to his home. This interim order was made notwithstanding the fact that the insurer in this instance was not simply denying the benefit but denying that there was even a policy of insurance with Mr. Brown.

2. *Federow v. Kingsway General Insurance Co.* [2000] O.F.S.C.I.D. No. 188

In this matter, the arbitrator ordered that the insurer pay \$526.37 per day for Mr. Federow to attend at the Anagram Treatment Centre as a result of him urgently requiring rehabilitation. This order based on urgency was made 2 years and 3 months after Mr. Federow's car accident.

### 3. *Singh v. Coseco Insurance* [2002] O.E.S.C.I.D. No. 33

In this matter, the arbitrator stated that additional grounds for an interim order could be the “blatant disregard by the insurer of the requirements of the Schedule”. The arbitrator stated that urgency does not mean that the person must be in desperate or extreme circumstances before being given assistance. In fact, in this arbitration, the arbitrator made an interim order that Mr. Singh’s income replacement benefits be paid notwithstanding a dispute by the insurer in stating that “the loss of a well-paying position would create a financial emergency in most families”.

The application for an interim order for benefits is under utilized. It is there for a reason and can efficiently avoid the “institutional delay” where benefits are urgently needed notwithstanding a dispute.

*David Payne, Partner*

## Key Employment Law Issues for Disabled Employees



*Robert Brent*

**I**n many cases, the injuries that someone suffers in a motor vehicle accident carry over to that person’s workplace, when their resulting disability means they cannot work or cannot perform their job in the same way.

What follows is a summary of some of the key employment law issues that may affect an employee (in a non-unionized workplace) who has become disabled.

Obviously, job security is a central concern for someone who cannot work after an injury.

In general terms, any employee can be terminated at any time. The real question is whether the employer terminates that person’s employment for cause (i.e. some wrongdoing) or without cause. The difference between the two is that an employee who is terminated without cause is entitled to advance notice of the termination, or pay in lieu of that notice. The length of the notice period, in weeks, will depend on numerous factors but it primarily rests on the terms of the employment contract and the employee’s length of service. Section 57 of Ontario’s *Employment Standards Act, 2000* establishes minimum notice periods based on an employee’s length of service.

Courts have concluded that conduct justifying dismissal for cause (i.e. without notice) must be wilful or deliberate. Because an absence from work due to illness or disability is not intentional, disability **cannot** be relied upon by an employer as cause to terminate a person’s employment. This does not mean that a disabled employee cannot be terminated **without** cause (i.e. by giving notice), it just means that the employer cannot rely upon the employee’s disability as cause to terminate his or her employment. Arguably, however, the notice period should run from the time that the employee is able to return to work and, where an employee becomes disabled **during** a notice period, passage of the notice period is suspended until the person could return to work. As well, all employee benefits must be maintained through minimum notice period under section 61 of the *Employment Standards Act, 2000*.

The notice period (i.e. compensation) afforded to any employee may be increased where the manner in which the employee is dismissed has breached the employer’s duty to act fairly and in good faith. Firing a disabled employee for cause has been held by the courts to be an example of bad faith, resulting in an extension of the notice period provided.

While an employer cannot rely on an employee’s disability in terminating his or her job, there is a separate legal doctrine that permits an employer to treat the employment contract as being at an end. This is called the doctrine of “frustration,” which applies to all kinds of contracts (not just employment contracts).

Under this doctrine, an employee is not considered to have been dismissed. Instead, the parties to the employment contract are seen as being incapable of performing the employment contract, putting their obligations at an end.

An employment contract is considered to be frustrated where the employee's inability to work, looked at before the dismissal, was of such a nature or appeared likely to continue for such a period that **further performance of the employee's obligations would either be impossible or radically different from that to which the parties originally agreed.**

This doctrine is not to be lightly invoked and, as a rule of thumb, an employee must have been disabled for 18 months to 2 years before the employment contract can be said to have been frustrated.

A court will consider the following factors:

1. **The Terms of the Contract:** i.e. when a contract provides for sick pay/LTD benefits, it cannot be frustrated so long as the employee returns to work, or appears likely to return, within the period during which sick pay is payable;
2. **How Long Employment was Likely to Last:** i.e. long term or temporary employee?;
3. **Nature of the Employment:** i.e. is employee one of many in same role, or fills a key post that cannot be left vacant;
4. **Nature and Duration of Disability/Prospects for Recovery:** i.e. it is more likely the employment relationship has been destroyed where there is greater incapacity and/or longer period that disability has persisted or is likely to persist;
5. **Period of Past Employment:** i.e. a longstanding relationship is not so easily destroyed.

All of this must be viewed in light of employer's duty to accommodate a disabled employee under the Ontario *Human Rights Code*. In particular, an employer cannot discriminate against an employee on the basis of disability and has a duty to accommodate an employee's disability to the point of "undue hardship". (Various resources available on Ontario Human Rights Commission website: <http://www.ohrc.on.ca> ). The legal issues surrounding the rights of a disabled employee are complex and, obviously, can arise at a time when an injured individual is at his or her most vulnerable. If you or someone you know has suffered an injury and requires assistance dealing with these workplace issues, please feel free to consult Robert Brent by telephone at 416-868-3218 or by email at [rbrent@thomsonrogers.com](mailto:rbrent@thomsonrogers.com).

*Robert Brent*

## Upcoming ...

*September 30, 2004 – "Hospital to Home...Issues in Mild to Moderate ABI"*

The Head Injury Clinic of St. Michael's Hospital

For more information: [http://www.thomsonrogers.com/Workshop\\_Information\\_H2H.pdf](http://www.thomsonrogers.com/Workshop_Information_H2H.pdf)

*October 21, 2004 – "Leap of Faith"*

Brain Injury Association of Niagara

For more information: <http://www.niagara.com/bian/conf.htm>

*November 18-19, 2004 - "Exploring the Spectrum of Brain Injury: Sharing the Tools of the Trade"*

Toronto Acquired Brain Injury Network

For more information: <http://www.abinetwork.ca/conference2004/>

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