FINDING SOLUTIONS TO KEY CHALLENGES

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Squeezing the Most Out of $50,000

One of the important challenges facing accident victims who have suffered a serious injury, that is not catastrophic or may not be determined to be catastrophic until the second anniversary following the accident, is making the best use out of the lower medical and rehabilitation benefit. It should be remembered that assessment and examination costs are also deducted from the new $50,000 limit.[1] Those suffering serious injury are likely to exhaust the $50,000 limit long before the two year mark, in the event that they might be candidates for catastrophic designation, and almost certainly before any tort action can be resolved. It is incumbent upon those assisting these accident victims to help in getting the most out of the available limits. Here are just a few suggestions;

1. If the injured party has a tort action, assessments obtained for purposes of the tort claim can likely be used for both the tort claim and the accident benefits claims. The issues usually overlap. Most of these assessments will likely be recoverable in the tort claim. Where disbursements are not considered assessable in the tort claim, provision will have to be made for underwriting those costs.

2. Consult with the treatment team to ensure everyone is on the same page concerning the best utilization of resources, i.e. no one treatment modality.

3. Minimize expenses which have been potentially wasteful in the past. For example:

    a. use Skype, emails and telephones for follow up consults and not have any meetings subsequent to the initial meeting;

    b. develop a team that works well together to reduce repetitive communications – you need a strong team;

[1] There is no deduction for assessment and examination costs requested by the insurer under section 44 of the new SABS.

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c. obtain reports from the team at key times. Do not allow monthly reports simply because another month has gone by;
d. arrange for the team to have treatments at the same location to minimize transportation costs;

e. have the insurer work with the insured more to make direct payments for rehabilitation items. Case coordinators presently do this and will typically complete much of the paperwork. Teach the insured and any family to complete this paperwork so as to minimize the case coordinator's costs;

f. group multiple treatment plans into one treatment plan to avoid multiple assessment costs.

Solutions When Non-Catastrophic Limits are Gone

1. If there is a tort action, try to obtain an advance from the tortfeasor to fund ongoing treatment. It is often reasonable to expect a tortfeasor to advance money for treatment-related issues as this will assist the plaintiff in mitigated her damages and ultimately might expose the tort insurer to a smaller claim. Where the tort insurer denies an advance for reasonably required treatment, it will not permit the tortfeasor to argue a failure to mitigate.

2. The public health care system is always the first payor. Where publicly funding health care is available, claimants should ensure that they receive the maximum benefit from the available services.

3. Some claimants relying on a whole person impairment to determine if their injury is catastrophic should give early consideration to that possibility if such a claim might be viable.

4. Consider an interim benefits motion at FSCO for an interim declaration of catastrophic status.

5. If a disputed catastrophic status must go to full arbitration, ensure regular treatment plans are still submitted to the insurer to ensure that outstanding denied claims are appropriately recovered in the event you do obtain a declaration of catastrophic status.

6. Take all reasonable steps to expedite the tort claim. This means commencing the tort action very soon after being retained. It then requires active steps to complete all interlocutory steps and perhaps even an application to the court for an expedited trial date.

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Escaping the Minor Injury Regulation Clause

Section 18 of the amended SABS states:

> 18. (1) The sum of the medical and rehabilitation benefits payable in respect of **an insured person who sustains an impairment that is predominantly a minor injury shall not exceed $3,500** for any one accident, less the sum of all amounts paid in respect of the insured person in accordance with the Minor Injury Guideline.

Section 14(2) of the amended SABS in regard to attendant care states:

> 14. Except as otherwise provided in this Regulation, an insurer is liable to pay the following benefits to or on behalf of an insured person who sustains an impairment as a result of an accident:
>
> …
>
> (2) if the impairment is not a minor injury, attendant care benefits under Section 19.

In short, med/rehab benefits are limited to $3,500 and no attendant care is payable if the insured has suffered a minor injury.

Minor injury is defined in Section 3(1) as:

> "Minor injury" means a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and any clinically associated sequelae.

One has to query whether the condition of chronic pain or a severe psychological disability arising from a whiplash injury would qualify as a clinically associated sequelae and accordingly, not be compensable beyond the minor injury limits.

The SABS provide for a "minor injury guideline" to be issued by the Superintendent of Insurance that may potentially allow the passing of new definitions of minor injuries by regulation and not legislation. The minor injury guidelines are defined as a guideline "that establishes a **treatment framework**" in respect of one or more injuries and not new definitions. If the guideline when completed is truly a treatment framework, it is likely that the limitations to minor injury will not be expanded beyond that contained in the new SABS.

Section 18(2) states that if a health practitioner determines and provides compelling evidence that the insured person had a pre-existing medical condition preventing the insured person from receiving maximal recovery from the minor

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injury, the $3,500 limit does not apply. It does not say “diagnosed” pre-existing medical condition. It does not indicate the nature of a pre-existing condition that might apply. It does not indicate whether the injured party’s predisposition, say as a thin-skulled person, would qualify as a pre-existing medical condition. The fact that “medical” modifies the word condition may result in some limitation on the ability to avoid the minor injury limit.

There is an issue about whether an injured party who is found not to be bound by the minor injury limit due to a pre-existing condition will be entitled to attendant care benefits. Under the SABS a person who suffers a minor injury is not entitled to attendant care. If they escape the minor injury limit, do they also avoid the prohibition from receiving attendant care?

Perhaps a challenge facing claimants seeking to avoid the minor injury limit on the basis of a pre-existing condition is an allegation by the insurer that the need for treatment arises out of the pre-existing condition rather than the accident. This is another potential challenge facing claimants.

Impact on Hospitals and Discharge Planning

For some claimants planning for prudent use of medical and rehabilitation benefits ought to begin prior to discharge from hospital. Understanding the recommendations of discharge planners is vital to making best efforts to ensure need care and rehabilitation is in place in a timely way.

To facilitate this process it would be helpful to have the team connect with the hospital prior to discharge. This may minimize costs for assessments if they can be done while the insured is in the hospital as opposed to at home. By having the assessments done in the hospital prior to discharge, the rehabilitation team can move more easily and seamlessly into treatment.

By conducting assessments prior to discharge, the team can access hospital resources.

From the perspective of the patient, the sooner they become fully informed of their rights and entitlements the better. A fully informed patient will then be in a position to make appropriate treatment choices, make prudent use of limited resources and ensure the timely pursuit of any tort rights they may have to make up the shortfall.

By coordinating with the discharge planning team at the hospital, costs can be reduced by having the health care workers and physicians address recommendations for discharge at once.

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Unfair or Deceptive Acts or Practices

Section 439 of the *Insurance Act*, R.S.O. 1990, c. I.8 as amended provides:

> 439. Prohibition – no person shall engage in any unfair or deceptive act or practice.

Section 447(2) of the *Insurance Act* states:

> 447(2) Every person is guilty of an offence who:
>
> …
>
> (d) contravenes this *Act* or the Regulation.

Section 447(3) of the *Insurance Act* states:

> 447(3) On conviction of an offence under this *Act*, the person convicted is liable on a first conviction to a fine of not more than $100,000 and on each subsequent conviction, to a fine of not more than $200,000.

Ontario Regulation 7/00, defines an unfair or deceptive act or practice. Section 1(9) of the Regulation states:

> 1. For the purpose of the definition of "unfair or deceptive act or practice" in Section 438 of the *Act*, each of the following actions is prescribed as an unfair or deceptive act or practice:
>
> (9) any conduct resulting in unreasonable delay in, or resistance to, the fair adjustment and settlement of the claims.

Presently (and up to September 1, 2010) section 5(2) of the unfair or deceptive act or practice regulation stated that if an insurer determined its insured was not entitled to a claimed for accident benefit or that the person did not have a catastrophic impairment without first having a completed Section 42 examination supporting this determination, this was an unfair or deceptive practice.

Section 5 of the *Unfair or Deceptive Practices Act* will no longer be applicable for claims after September 1, 2010 regardless of the date of the accident. The reason for this is that there is no longer any positive obligation on the insurer to obtain a Section 42 examination prior to denial.

A new section 6 is to be added effective September 1, 2010. It provides:

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6. For the purposes of the definition of "*unfair or deceptive acts or practices*" in section 438 of the Act, each of the following actions is prescribed as an unfair or deceptive act or practice in relation to a claim for statutory accident benefits under the *Statutory Accident Benefits Schedule – Effective September 1, 2010*, made under the Act (in this section referred to as the *Schedule*):

    1. The failure or refusal of an insurer without reasonable cause to pay a claim for goods or services or for the cost of an assessment within the time prescribed for payment in the *Schedule.*

    2. The making of a statement by or on behalf of an insurer for the purposes of an adjustment or settlement of a claim if the insurer knows or ought to know that the statement misrepresents or unfairly presents the findings or conclusions of a person who conducted an examination under section 44 of the *Schedule*.

It is my opinion that Section 6.1 of the new Regulation along with Section 1.9 (which does survive) will be of greater use than it has in the past.

Under the existing Statutory Accident Benefit Schedule, almost all insurers referred submitted treatment plans which they did not approve for a Section 42 examination and report. Once the insurer received the report stating that the claim was not reasonable or necessary, the insurer could rely on the report for its denial, making it very difficult to argue the insurer's actions were without reasonable cause.

Now that adjusters have the power to deny claims without necessarily referring it out for a Section 42 exam (and they will), now section 44 under the new SABS, they may be held accountable for their decision.

If an adjuster is denying claims by, in effect, acted as the medical/rehab expert all on his or her own, the adjuster will be held accountable if an arbitrator or court determines the refusal was without reasonable cause. If evidence is submitted to the arbitrator or judge showing the claim was eminently reasonable, the adjuster/insurer has by definition, committed an unfair or deceptive act or practice.

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