

Appeal P09-00009

OFFICE OF THE DIRECTOR OF ARBITRATIONS

SECURITY NATIONAL INSURANCE CO./MONNEX INSURANCE MGMT. INC.
Appellant

and

H.T.
Respondent

BEFORE: Delegate Lawrence Blackman

REPRESENTATIVES: Mr. Christopher A. Caston for the Appellant
Ms. Deanna S. Gilbert and Mr. David A. Payne for the Respondent

HEARING DATE: April 14 and 21, 2009
Written submissions were received by May 5, 2009

**APPEAL PRELIMINARY
ISSUES ORDER**

Under section 283 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, it is ordered that:

1. Leave to file fresh evidence in this appeal is refused and paragraphs 68 to 70 of the Respondent's Written Submissions on Appeal are struck.
2. Leave to appeal the Arbitrator's February 9, 2009 preliminary decision at this time, sought pursuant to Rule 50.2 of the *Dispute Resolution Practice Code* (Fourth Edition, Updated – October 2003), is refused.
3. A stay of the Arbitrator's February 9, 2009 decision, sought pursuant to subsection 283(6) of the *Insurance Act*, R.S.O. 1990, c. I.8, is denied.
4. The Appellant shall pay the Respondent her legal costs of this preliminary issues appeal, fixed in the amount of \$5,539.68.

Lawrence Blackman
Director's Delegate

June 4, 2009
Date

REASONS FOR DECISION

I. NATURE OF THE APPEAL

The Respondent, H.T., was injured in a motor vehicle accident on September 8, 2003, and applied to her first-party automobile insurer, Security National Insurance Co./Monnex Insurance Mgmt. Inc. (the “Appellant”), for statutory accident benefits payable pursuant to the *Schedule*.¹

The Respondent’s August 13, 2008 letter provided the Appellant with an OCF-19 Application for Determination of Catastrophic Impairment signed by Dr. T. Biederman, a psychologist, solely based on a mental or behavioural disorder. In response, by OCF-25 sent September 10, 2008, the Appellant sought the Respondent’s attendance at four in-person examinations, pursuant to section 42 of the *Schedule*, in late October and early November 2008, with a psychiatrist (Dr. A. Luczak), a neurologist, an occupational therapist and an orthopaedic surgeon.

In September and early October 2008, the Respondent attended previously scheduled insurer examinations with Dr. L. Jerome, a psychiatrist, as well as a dentist and a physiatrist, to determine her non-catastrophic entitlement to certain benefits under the *Schedule*.

Dr. Jerome’s September 12, 2008 report opined that the severity and duration of the Respondent’s functional impairment and symptoms warranted serious consideration of an in-patient assessment and treatment program for a Post-Traumatic Stress Disorder. Dr. Jerome found that, as a result of the accident, the Respondent had suffered a complete inability to carry on her normal life.

Dr. Biederman’s subsequent September 22, 2008 letter indicated that the Respondent suffered significant setbacks with the stress of assessments and became actively suicidal. Dr. Biederman stated, in reference to the upcoming examinations, that she could not “stress strongly enough the risk that 4 assessments in the span of a little over 2 weeks” posed to the Respondent.

¹ *The Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996*, Ontario Regulation 403/96, as amended.

On September 19, 2008, the Respondent's counsel advised the Appellant that the Respondent would not attend the section 42 catastrophic impairment examinations. By Explanation of Benefits dated October 23, 2008, the Appellant determined that the Respondent's impairments did not meet the criteria for catastrophic impairment as a result of the Respondent's failure or refusal to attend the required examinations. The Appellant sought payment from the Respondent of \$5,975 for her non-attendance at the assessments. The Appellant also advised that \$33,473.49 remained from the non-catastrophic medical/rehabilitation limits of \$100,000.

The Respondent's Application for Arbitration, dated November 24, 2008, sought, in part, a determination that the Respondent suffered from catastrophic impairment and urgent directions regarding attendance at the section 42 examinations. The Appellant's December 31, 2008 Response stated, in part, that it was entitled to conduct an examination under section 42 to investigate the issue of catastrophic impairment and that it had "the sole and unqualified right to choose the assessor(s) for the said examination."

The Respondent served an arbitration motion seeking, amongst other things, an order that the Appellant request an opinion from Dr. Jerome whether the Respondent had suffered a catastrophic impairment in accordance with Chapter 14, Mental and Behavioural Disorders, of the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993 or, in the alternative, if Dr. Jerome was unable to provide an opinion, directions on the scope of the Appellant's section 42 examinations on the issue of catastrophic impairment. The motion was heard by Arbitrator Wilson (the "Arbitrator") on January 20, 2009.

The Arbitrator's February 9, 2009 order, at page 3 of his decision, provided that:

[The Appellant] is required to proceed with a determination of catastrophic impairment for H.T., at this time, on the basis of currently available assessments, reference of the issue to those past assessors and a review of the available documentary evidence. At this time, given [the Respondent's] current condition it is not reasonable to schedule further in-person examinations, although [the Appellant] may refer supplementary questions to the previous examiners, with regard to the claim for catastrophic impairment. It would therefore be reasonable to refer the issue back to Dr. Jerome who has expertise in catastrophic impairments, and who has recently examined [the Respondent] for a further paper review of the issue of catastrophic impairment from a psychiatric perspective.

II. BACKGROUND

The Appellant's Notice of Appeal, dated March 11, 2009, sought leave to appeal the Arbitrator's February 9, 2009 preliminary issue decision and requested a stay of the arbitration order.

My April 15, 2009 letter confirmed the parties' agreement that the following three preliminary issues were first to be determined:

1. Should, at the Respondent's request, the following fresh evidence be received regarding both the preliminary issues and, if the appeal is not rejected, the main appeal:

- (a) The psychological report of Kaplan and Kaplan dated February 25, 2009.
- (b) The letter from Thomson Rogers dated March 17, 2009.
- (c) The Arbitrator's letter dated March 13, 2009.
- (d) An Attendant Care Form 1, dated April 6, 2009.
- (e) An Application for Benefits, dated April 8, 2009.
- (f) The Respondent's letter request to the Appellant to find a case manager, dated March 19, 2009.
- (g) The initial and follow-up letters from the Respondent requesting confirmation as to how much is left of the \$100,000 medical/rehabilitation statutory limits?

Included in the issue of fresh evidence is the Appellant's request to strike paragraphs 68-70 of the Respondent's Written Submissions on Appeal received March 25, 2009.

2. Should the appeal from the Arbitrator's preliminary decision dated February 9, 2009 be rejected until the issues in dispute in the arbitration have been finally decided, in accordance with Rule 50.2 of the *Dispute Resolution Practice Code* (Fourth Edition, Updated – October 2003)?
3. If the appeal is not rejected, should I exercise my discretion pursuant to subsection 283(6) of the *Insurance Act*, R.S.O. 1990, c. I.8, to stay the Arbitrator's Order?

The Appellant sought, ultimately, an order rescinding the Arbitrator's decision in its entirety, a declaration that it was entitled to conduct examinations under section 42 of the *Schedule* to investigate whether the Respondent had suffered a catastrophic impairment and that it had the

“sole and unqualified right to choose the assessor(s) for said examination,” and its legal costs at arbitration and on appeal.

The Appellant initially requested an order that the Respondent make herself available for in-person catastrophic assessments with Dr. Luczak, psychiatrist, as well as a neurologist and an occupational therapist. My April 15, 2009 letter confirmed that the Appellant withdrew from its prayer for relief its request for an order compelling attendance at the aforesaid examinations, the Appellant agreeing with the Arbitrator’s statement, at page 19 of his decision, that he had “no authority to order an insured to undergo a medical assessment.” In lieu, the Appellant requested an order that it was reasonable that the Respondent attend the medical examinations.

III. ANALYSIS

(a) Fresh Evidence

Delegate McMahon, in *Budd and Personal Insurance Company of Canada*, (FSCO P99-00032, January 8, 2000), adopted the following criteria regarding the introduction of fresh evidence on appeal:

- The evidence should generally not be admitted if, by due diligence, it could have been adduced at trial;
- The evidence must be credible, in the sense that it is reasonably capable of belief;
- The evidence must be relevant in the sense that it bears upon a decisive or potentially decisive issue in the trial; and
- The evidence must be such that, if believed, it could reasonably, when taken with the other evidence adduced at trial, be expected to have affected the result.

In addition to the documents noted above, the Respondent further filed a report of Dr. G.N. Swamy dated April 2, 2009, and April 2009 correspondence regarding attendant care, case manager services and a break-down of benefits paid to date. The Appellant sought an order that the Respondent’s counsel’s letter of September 18, 2008 be produced and be permitted as fresh evidence in this appeal.

The Appellant objected to the Respondent’s request to file fresh evidence, arguing that its

purpose was to remedy defects in the Respondent's position and, with due diligence, could have been made available for the arbitration motion.

I am not allowing the requested documents as fresh evidence in this preliminary issues hearing. The documentation appears, in significant measure, to endeavour to shore up the Respondent's position with evidence that could have been brought into existence prior to the arbitration motion. One questions the timing of a flurry of possible catastrophic claims, more than five years post-accident, in the two-month period between the Arbitrator's decision and this preliminary issues appeal hearing. I am otherwise not persuaded that the documentation presented by either party would be expected to affect the result of this preliminary issues hearing.

The Respondent agreed that paragraphs 68 to 70 of its written submissions rested on its motion to file fresh evidence. Given my decision regarding the requested fresh evidence, paragraphs 68 to 70 of the Respondent's Written Submissions on Appeal are struck.

(b) Whether to Accept the Appeal from a Preliminary or Interim Order

Rule 50.2 of the *Dispute Resolution Practice Code* (Fourth Edition, Updated – October 2003), (the "Code") provides that:

A party may not appeal a preliminary or interim order of an arbitrator until all of the issues in dispute have been finally decided, unless the Director orders otherwise.

Delegate Makepeace, in *Allstate Insurance Company of Canada and Torok*, (FSCO P01-00021, May 29, 2001), set out the following criteria in determining whether to accept an appeal from a preliminary or interim order:

The purpose of Rule 46.2 is to facilitate the most cost-effective resolution of disputes by minimizing the time and money spent on procedural or collateral matters. The decision whether to hear an appeal of a preliminary order is discretionary. As Delegate Naylor stated in *General Accident and Glynn*, the over-arching principle guiding the exercise of the discretion is that the rule "should be broadly interpreted to produce the quickest, most just and least expensive resolution of the dispute." The criteria to be considered include the *apparent strength of the appeal, the importance or novelty of the issue raised*, and *whether rejecting the appeal or hearing it will prejudice either party*. [emphasis added]

The Appellant submitted that while the decision whether to accept an appeal from a preliminary order is discretionary, this discretion is not absolute and must be exercised reasonably, in accordance with the principles of natural justice.

The Appellant submitted that “an appellate court may intervene if [a trier of fact] misapprehends or disregards relevant evidence, fails to appreciate the evidence, makes a finding not reasonably supported by the evidence, or draws an unreasonable inference from the evidence.” Further, citing the Ontario Court of Appeal in *Hock (Next Friend of) v. Hospital for Sick Children* (1998) O.A.C. 321, the Appellant submitted that the adjudicator’s failure to consider essential evidence may constitute an error of law and justify appellate intervention. Citing the Ontario Court of Appeal in *R. v. M. (N.J.)*, WL 704657, the Appellant submitted that where an adjudicator “employs a highly selective approach to the evidence and fails to explain either the basis for the selection of positive and rejection of negative evidence, this amounts to an error of law.”

The Appellant argued that leave should be granted to hear the appeal from the Arbitrator’s February 9, 2009 decision for the following reasons.

1. Citing *Zurich Insurance Company and Lenti*, (FSCO P98-00030, December 18, 1998), the Appellant submitted that the standard of review is correctness. The Appellant argued that the Arbitrator had erred in law and exceeded his jurisdiction by (a) entertaining a premature motion in the complete absence of any factual basis for urgency and (b) ordering that the Appellant proceed with a determination of catastrophic impairment solely on the basis of a paper review, contrary to sections 40(6), 42(1) and 42(10)(b) of the *Schedule*, finally disposing of the Appellant’s rights under these provisions.
2. The Arbitrator exceeded his jurisdiction in ordering the Appellant to proceed in determining catastrophic impairment and directing how it should be done. Nothing in subsection 40(6) of the *Schedule* mandates that an insurer must make a determination of catastrophic impairment when faced with an insured’s refusal to attend a section 42 insurer examination, nor is there a provision permitting an arbitrator to order same.

3. The Arbitrator erred in law by second-guessing the Appellant's decisions regarding the conduct of and choice of experts for the catastrophic impairment examination and failing to consider that an insurer has the *prima facie* right to choose a medical practitioner it feels is most competent to deal with the issues at hand.
4. The Appellant has never conducted an in-person examination of the Respondent regarding catastrophic impairment, while the Respondent is content to not attend any further in-person assessments, as she has all the reports she requires. The Appellant prefers not to use Dr. Jerome to conduct a catastrophic impairment examination. There is no basis for showing that Dr. Jerome is experienced and qualified to assess and categorize degrees of psychological impairment.
5. The Arbitrator usurped the role of the hearing arbitrator. The Arbitrator should have simply dismissed the Respondent's motion and referred the matter to the hearing arbitrator. Accordingly, the Respondent's motion was unnecessary and an inefficient and improper use of the Commission's resources and time.
6. The Ontario Court of Appeal held in *McCombie v. Cadotte*, [2001] O.J. No. 1286, that "a defendant has a *prima facie* right to choose the doctor who will conduct a medical examination." Nothing in the *Schedule* permits an arbitrator to order an insurer to use a particular medical practitioner. The Arbitrator, by saying it was reasonable to refer the issue of catastrophic impairment to Dr. Jerome, made this a directive and the effect of non-compliance would be that the Respondent was acting unreasonably. In this regard, the Arbitrator exceeded his jurisdiction, especially when he stated that he did not have authority to order a specific examination.
7. *Prudential of America General Insurance Company (Canada) and Chafe-Moote*, (FSCO P99-00044, September 8, 2000) provides that "second-guessing" by an arbitrator is only unfair if based on information not available to the insurer. In this case, the Arbitrator failed to consider that if the Appellant had earlier known Dr. Biederman's concerns regarding such examinations (that apparently went back to at least December 2007 regarding a tort defense medical examination), the Appellant could have arranged less

burdensome examinations, or at least have scheduled the catastrophic impairment examinations prior to the examinations it arranged for September 2008.

8. The Appellant submitted that the Arbitrator was highly selective as to what evidence to accept and what to ignore. The Arbitrator failed to note that Dr. Biederman's March 31 and May 5, 2008 correspondence did not advise that insurer assessments caused the Respondent stress, made her more suicidal or were in any way harmful or posed any risk of harm or injury to her. The Appellant submitted that it simply did not make any sense that Dr. Biederman would knowingly withhold such vital information that would, ostensibly, cause her patient irreparable harm. Further, the Arbitrator disregarded evidence that conflicted with Dr. Biederman's September 22, 2008 report (that for the first time in her long history of treating the Respondent, stated that insurer examinations were stressful to the Respondent, could pose a setback in her progress and result in a more heightened suicide risk), from which he drew improper inferences and which he gave undue weight. Further, the latter report came only in response to an unproduced letter of the Respondent's counsel, dated September 18, 2008.

9. The Appellant submitted that this appeal raises questions of general importance and novel and unresolved issues of statutory interpretation as to the scope of an insurer's rights under sections 40 and 42 of the *Schedule* and a party's right to choose its own medical experts and make full answer and defense. Issues specifically raised in this appeal are:
 - (a) The process by which insurers determine whether an insured person is catastrophically impaired. The Appellant submitted that the Arbitrator's decision mandates for the July 2009 arbitration what it can and cannot do in determining the issue of catastrophic impairment.
 - (b) Whether an arbitrator has jurisdiction to order an insurer to proceed with a determination of catastrophic impairment solely on the basis of a paper review without conducting an in-person examination, and whether an arbitrator has jurisdiction to determine how that paper review should proceed.

- (c) Whether an arbitrator can order “reasonable” terms by which an insurer should conduct a determination of catastrophic impairment, thereby implying that any other course of action would be unreasonable.
 - (d) Whether an arbitrator can order a specific examination to take place, in this case implicitly in regard to Dr. Jerome.
 - (e) Whether an arbitrator has jurisdiction to override the provisions of subsection 40(6) of the *Schedule*.
 - (f) Issues regarding all insurer determinations and examinations under section 42 of the *Schedule*, specifically when an insured asserts that he or she is not psychologically able to attend such examinations. If an arbitrator has unfettered jurisdiction and discretion to set out the process by which an insurer is to determine catastrophic impairment, then arguably the arbitrator also has discretion “to do just about [any] activity in relation to its adjusting and management of an insured’s accident benefits claim.”
 - (g) Accordingly, this appeal is of general public importance, addressing the issue of an insurer’s ability to control its own processes and an arbitrator’s general power and jurisdiction to manage the external and internal processes of insurers.
10. The Appellant submitted that there is sufficient time to hear this appeal before the arbitration hearing commencing July 13, 2009. Further, there was no basis for a finding of urgency to this matter requiring an interim order, the Respondent taking three and a half months from receipt of Dr. Biederman’s May 5, 2008 correspondence to the Respondent’s August 13, 2008 letter enclosing the OCF-19 Application package.
11. The Appellant disputed the Respondent’s allegations that she was approaching her non-catastrophic limits, that those limits might be reached prior to the arbitration and that she required case manager services, attendant care and housekeeping services. Rather, the Respondent was presently in no danger of not receiving accident benefits at catastrophic levels. Since September 8, 2003 the Respondent had still used up less than \$70,000 of her medical and rehabilitation benefits, or roughly \$13,000 a year. At this rate, the Respondent would not reach the non-catastrophic impairment limit of \$100,000 for another 2.3 years. The Respondent had never filed a Form 1 Assessment of Attendant

Care Needs, nor had she submitted any housekeeping and home maintenance invoices in the post-104 week period. Further, the Respondent had only been paid \$4,830 for the latter benefits in the initial 104-week period.

12. The Arbitrator erred in law in failing to reasonably exercise his discretion so as to balance the interests of both parties, such as having the Respondent attend an in-person examination with a treating physician who could ensure that the assessment was conducted in the least intrusive manner. Rather, the Arbitrator gave preference to the Respondent's interests, failing to consider the prejudice to the Appellant who was denied a reasonable opportunity to test the strength of the Respondent's claims.

The Appellant cited cases where a negative inference was drawn where experts had conducted a paper review rather than an in-person examination and submitted that there was a "real and substantial risk" that such an adverse inference would be made in this case. The Respondent noted the *Catastrophic Impairment Designated Assessment Centre Assessment Guidelines*, revised April 2002, requiring Designated Assessment Centres to conduct clinical assessments of a claimant regarding catastrophic determination. While the Respondent would be proceeding to the hearing with several in-person reports authored by treating practitioners, most notably Dr. Biederman, the Appellant would be irreparably prejudiced in being forced to proceed with merely an inferior paper review examination. The Appellant sought, in this case, balance and fairness.

13. The aforementioned was especially important, for if the Respondent was found to be catastrophically impaired, she would be entitled, in the Appellant's submissions, to (a) increased medical/rehabilitation benefits from \$100,000 for the ten-year period following the accident to \$1,000,000 over her life-time (b) increased attendant care benefits from \$72,000 (at a maximum of \$3,000 a month for 104 weeks) to \$1,000,000 (at a maximum of \$6,000 a month over her entire life) and (c) increased housekeeping and home maintenance benefits from a maximum of \$100 a week for 104 weeks to \$100 a week over the course of her life.

The Appellant submitted that an appellate decision on these issues is required prior to an arbitration hearing, otherwise the issues will be rendered moot.

The Respondent submitted that the Appellant, notwithstanding raising, by its count, 18 issues in this appeal, was effectively attempting to get a “second kick at the can.” The Respondent brought her arbitration motion to determine the scope of the requested examinations. The Respondent cited *Lombardi and State Farm Mutual Automobile Insurance Co.*, (FSCO P01-00022, February 26, 2003) that a finding of fact in the absence of any supporting evidence is an error of law, while a finding of fact with insufficient evidence is not reviewable as such.

The Respondent argued that had she not brought the motion, the issue would likely have arisen at the arbitration hearing, requiring that latter to be adjourned to allow the Appellant to conduct assessments under restricted parameters.

The Respondent submitted that the Arbitrator did not compel the Appellant to consult with Dr. Jerome, only that it would be reasonable to do so. The Arbitrator recognized that he had no authority to mandate that an insurer undertake a specific examination. The Respondent submitted that the Appellant failed to provide any jurisprudence for the principle that an arbitrator is barred from speaking to the reasonableness of a given course of action.

The Respondent further argued that the Appellant’s claim that it had the “sole and unqualified right” to choose its examining assessor ignored the qualifying words of section 42 of the *Schedule* that the examination be “reasonably necessary.” Further, the Appellant could not point to any evidence to explain why it was reasonably necessary for the Respondent to attend orthopaedic, neurological and occupational therapy assessments to determine whether the Respondent’s psychiatric condition amounted to a catastrophic impairment.

Regarding whether the appeal raised questions of general importance or novel issues, the Respondent submitted that many cases have considered the meaning of “reasonably necessary” “within the context of different case-by-case fact scenarios.” As the Arbitrator did not order an exclusive paper review or a specific examination, nor did he imply that any other course of

action other than having Dr. Jerome do a paper review was unreasonable, the appeal did not raise these questions.

As to prejudice, the Respondent argued that the potential prejudice to the Appellant was outweighed by the real prejudice to herself. The Respondent noted the three in-person insurer assessments held in September and October 2008, including Dr. Jerome's psychiatric assessment. The latter's October 16, 2008 report followed the Respondent's August 18, 2008 OCF-19 submission and the Respondent's September 19, 2008 written advice that she would not attend further in-person examinations and preceded the Appellant's October 23, 2008 determination of non-catastrophic impairment based on the Respondent's non-attendance.

Further, the Appellant had failed to give any reason, or file any evidence, why it would not consult with Dr. Jerome, other than it was not its preference. The Respondent argued that there was a shared prejudice, maintaining that Dr. Biederman never prepared a catastrophic impairment report and that her medical expert who did, never met the Respondent.

I am not persuaded that I should exercise my discretion pursuant to Rule 50.2 of the *Code* to accept this appeal from a preliminary order of an arbitrator.

Regarding the first criterion set out by Delegate Makepeace in *Torok*, there are significant concerns as to the apparent strength of this appeal.

The Appellant submits that the Arbitrator exceeded his jurisdiction by entertaining a premature motion. Rule 67.2 of the *Code*, however, provides that a party may request a preliminary or interim order "at any stage within a proceeding," pending a final order. Rule 67.1 of the *Code* provides that an adjudicator "may make preliminary or interim orders within a proceeding, pending a final order."

The Appellant submits that it has the sole and unqualified right to determine the manner of the examinations. Subsection 42(1) of the *Schedule*, however, provides that for the purposes of assisting an insurer to determine if an insured person is or continues to be entitled to a benefit under this Regulation for which an application is made, an insurer may, *as often as is reasonably*

necessary, require an insured person to be examined under this section by one or more persons chosen by the insurer, as specified.

Subsection 42(4) of the *Schedule* provides that whenever the insurer requires an insured person to be examined under this section, it is mandated to provide the insured person with a notice setting out, amongst other things, the reasons for the examination and the name of the person or persons who will conduct the examination, the regulated health professions to which they belong and their titles and designations indicating their specializations, if any, in their professions.

Subsection 42(10)(b) of the *Schedule* provides that if the attendance of the insured person is required at the examination, the insured person shall attend the examination and submit to all **reasonable** physical, psychological, mental and functional examinations requested by the person or persons conducting the examination.

These statutory provisions do not give an insurer the sole and unqualified right to determine the assessments or the assessors. That right is qualified by the word “reasonable.” Nor is the information required to be provided by subsection 42(4) of the *Schedule* without purpose. Rather, that information is mandated in order to establish the reasonableness of the assessments requested and the assessors selected. That the examinations in question in this case pertain to the issue of catastrophic impairment or that the potential increase in available benefits may be significant does not eliminate the analysis of whether the proposed examinations and the examiners are reasonable.

The Court of Appeal in *McCombie* did not address section 42 of the *Schedule* but rather medical examinations under clause 258.3(1)(d) of the *Insurance Act*. Nonetheless, the decision does not support the proposition that an insurer has the sole and unqualified right to determine medical assessors. Rather, the Court stated that while a defendant had a *prima facie* right to choose the doctor who will conduct the examination, “the court has a discretion, to be exercised on reasonable grounds, to name another doctor.” Pitt J., in *Smith v. Liberty Life Assurance Co. of Boston*, [2003] O.J. No. 2966, in addressing subsection 105(3) of the *Courts of Justice Act*, R.S.O. 1990, c. C.43, did not vary from *McCombie*.

The Appellant submits that the Arbitrator was highly selective regarding what evidence to accept. The Appellant, however, does not submit that there was no factual basis for the Arbitrator's decision, the Arbitrator having before him the report of the treating psychologist, Dr. Biederman, of the increased suicide risk should the further requested in-person examinations proceed. Dr. Biederman's concerns, albeit more abbreviated, were first communicated to the Appellant by the Respondent's counsel by letter dated September 19, 2008, almost a month prior to the release of Dr. Jerome's report, which notes on page 10 the date of October 15, 2008.

The Appellant submits that the Arbitrator usurped the role of the hearing arbitrator. Rule 33.1(d) of the *Code*, however, provides that a specific function of the pre-hearing process is to determine procedural and preliminary issues. The Arbitrator specifically qualified his order regarding attendance with the words "at this time." Further, rather than being an inefficient and improper use of resources and time, the motion endeavoured to avoid having the issue being first addressed at the arbitration hearing that could result in a preventable adjournment, contrary to Rule 1.1 of the *Code* that these Rules be interpreted to produce the most just, quickest and least expensive resolution of the dispute.

Turning to the second criterion in *Torok*, I am not persuaded of the importance or novelty of the issues raised in this appeal. Numerous decisions have addressed the question of reasonableness of a section 42 assessment on a case-by-case basis. As stated above, I am not persuaded that because the examinations in question pertain to catastrophic impairment or that the potential increase in available benefits may be significant make this appeal of importance or novelty such that it should be accepted at this preliminary stage, as an exception to the usual rule.

Regarding prejudice, it is, at this point, speculative how the hearing arbitrator may proceed. It is speculative as to what weight the hearing arbitrator may give to various medical evidence. The Arbitrator noted Dr. Jerome, who did perform an in-person psychiatric assessment on behalf of the Appellant, as but one option available to the Appellant. It is speculative that the hearing arbitrator will make an adverse inference if the Appellant does not follow this option.

In any event, should the Appellant decide to proceed with Dr. Jerome preparing a report and should that report be unhelpful to the Respondent, the Arbitrator's decision would certainly assist

to negate any new argument by the Respondent that Dr. Jerome's expertise was now being used improperly for a purpose outside the section 42 examination for which he had been retained.

I am thus persuaded, to use the words from *Torok*, to exercise my discretion to reject this appeal from a preliminary issue at this time on the basis that this will "facilitate the most cost-effective resolution" of this dispute by "minimizing the time spend on procedural or collateral matters."

One notes the significant legal costs to date, as set out below, before either written or oral submissions have been completed on the substance of this appeal. Regarding expeditiousness, I am not persuaded that it is an answer that notwithstanding it is now more than five years after the accident, that the Respondent has not yet completely exhausted her non-catastrophic benefits.

Importantly, I also note that the Appellant's right of appeal is not lost, it is merely postponed pending the final determination of all of the issues in dispute, as contemplated by Rule 50.2 of the *Code*.

(c) Stay of the Arbitrator's February 9, 2009 Order

Subsection 283(6) of the *Insurance Act* provides that "[a]n appeal does not stay the order of the arbitrator unless the Director decides otherwise." This is repeated in Rule 50.3 of the *Code*.

Delegate McMahon, in *Guardian Insurance Company of Canada and Armstrong*, (FSCO P00-00037, July 20, 2000), stated that a "stay is the exception rather than the rule." In determining whether a stay should be granted, Delegate McMahon adopted Delegate Richardson's criteria in *Canadian Home Assurance Company and Scavuzzo*, (OIC P-000626, May 18, 1992), namely:

1. the *bona fides* of the appeal;
2. the substance of the grounds for appeal; and,
3. the hardship to the respective parties if a stay is granted or refused.

The Appellant submitted that a stay should be granted because:

- (1) it had raised *bona fide* issues of law and jurisdiction.
- (2) the Respondent would suffer no hardship if a stay were granted (being currently paid all her benefits and having not exhausted her non-catastrophic entitlement), while there

would be irreparable prejudice to the Appellant, being forced to proceed to a hearing determining catastrophic impairment with a “mere paper review,” while the Respondent would have the advantage of in-person assessment reports from her treating practitioners.

- (3) In the absence of a stay being granted, the issues in this appeal would be rendered moot, as the Appellant would have to comply with the arbitration order.

Having denied the Appellant leave to appeal, its request for a stay of the Arbitrator’s February 9, 2009 order is also denied. In any event, regarding *bona fides*, there is little doubt as to the ardour in which the Appellant presents its case. However, as set out above, I am not persuaded that the substance of the grounds for appeal or the relative hardship to the parties merit this arbitration being stayed.

IV. EXPENSES

Both parties initially requested, pursuant to Rule 79 of the *Code*, their legal expenses of this appeal proceeding. During oral submissions, however, the Appellant submitted that considering the novelty of the issues raised, both parties should each bear their own appeal expenses. In the event that legal expenses were awarded, the Appellant provided a Bill of Costs of \$3,305.15, including 32.3 hours at \$81.44 an hour (normally \$180 an hour being charged) and nine hours, at \$46 an hour, for a student-at-law.

The Appellant submitted that its total hours (41.3) were less than the Respondent claimed (42.1 hours), notwithstanding it had the onus of proof. It submitted that the hourly rate claimed for the Respondent’s counsel called in 2008 far exceeded the appropriate Legal Aid rate of \$77.56. The Respondent had no dispute with the \$150 hourly rate claimed by counsel called in 1984.

The Respondent sought \$6,984.86 in legal expenses, including 42.1 hours at \$150 an hour. The Respondent indicated it was time consuming to address the eighteen issues raised by the Appellant and endeavouring to appropriately narrow her submissions. The Respondent submitted that the hourly rates sought were less than what is actually charged by counsel.

In this case, I find that:

1. The Respondent is entitled to 85% of her reasonable legal expenses of this present appeal from a preliminary order. Pursuant to Rule 75.2 of the *Code*, the relevant considerations are that the Respondent was successful regarding the Appellant's request for leave to appeal and the stay, and that I was not persuaded that the Appellant had raised novel issues, the latter also being a criterion for granting leave. The Respondent was not successful on its request to file fresh evidence. However, the latter issue represented a relatively minor and subsidiary part of this appeal.
2. The 42.1 hours claimed by the Respondent is reasonable. The Appellant itself claimed 41.3 hours. In this regard, I note:
 - (a) the Appellant's seventy pages of written argument in its Notice of Appeal and subsequent written submissions, in addition to its Appeal Book and three volumes of Books of Authorities;
 - (b) The Respondent's 26 pages of written submissions, in addition to her Appeal Book and Brief of Authorities; and,
 - (c) Oral submissions received on April 14 and 21, 2009.
3. Mr. Payne is entitled to an (undisputed) hourly rate of \$150 an hour. The 12.4 hours claimed, inclusive of GST, total \$1,953. Ms. Gilbert does not set out her usual hourly rate. It is not disputed that she was called in 2008. I found the Respondent's submissions thorough and of assistance. I award \$135 an hour for Ms. Gilbert, which is a modest amount, specifically in comparison with even partial indemnity costs awarded by the Court. Inclusive of GST, the 29.7 hours claimed equal \$4,209.98. No objection is taken to the \$354.29 claimed by the Respondent for disbursements. I find these research, courier and photocopying charges reasonable. The total is \$6,517.27. 85% is \$5,539.68, which I allow the Respondent as her legal costs of this appeal from a preliminary order.

Lawrence Blackman
Director's Delegate

June 4, 2009
Date