TOP TEN ACCIDENT BENEFIT CASES YOU NEED TO KNOW

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Cases that are important from a lawyer's point of view often involve procedural or technical issues. To a Health Care practitioner these issues are of no interest. You care about how you can best access the SABS resources to help the patient and her family. The cases summarized below represent a selection of Court and Arbitration decisions from the past half decade which illustrate the scope and flexibility of the accident benefit policy when the patient's rights are vigorously pursued.

You will probably know of some of the decisions – particularly those on the process for Catastrophic Designation. I thought it useful and important to include these decisions to refresh our collective memories and as an inspiration for the creative thinking that will continue to be essential to expand the patient's rights under the SABS.

Catastrophic Designation

1. ***Desbiens* v. *Mordini* (2004)**

This decision is a pioneering analysis of the interaction of the AMA Guides with the SABS Schedule in which they are incorporated by reference. Justice Speigel treated the Guides as an integral part of the legislation, rather than as a free standing text, making them subject to well established principles of statutory interpretation.

In 1986, Mr. Desbiens fell off a roof and was rendered paraplegic at T11-12. In November 1, 1999, he was hit by a car while wheeling down a sidewalk.

The main issue at the trial before Justice Speigel was whether as a result of additional injuries sustained in the car accident (which included a spiral fracture of the femur), Desbiens was entitled to Catastrophic Designation under Sections 5 (1) f) and g) of the SABS regulation. Justice Speigel found that Desbiens did not sustain a Class 4 or Class 5 impairment pursuant to Subsection g).

He found that without taking into consideration Desbien's paraplegia he had suffered a 40% whole body impairment as a result of the MVA. Justice Speigel agreed with the plaintiff's doctor that Desbien's MVA related impairments must be considered in the context of his paraplegia and that a 40% impairment to a paraplegic is "qualitatively much worse than to an able bodied person". He found Desbiens catastrophically impaired under Subsection f) for this reason.

In addition, he found that Desbiens also met the 55% threshold under subsection f) when his psychological impairments (25%) were combined with his musculoskeletal impairments (40%) in the appropriate manner.

2. ***Augello* v. *Economical Mutual Insurance Company* (2008)**

This Arbitration decision, which was released in December 2008, is evidence of how hard the insurers have fought the Desbiens approach to the determination of catastrophic impairment. More than 4 years after Desbiens was released, the insurer refused to accept the Speigel approach of 'stacking' impairments by assigning percentages to mental and behavioral disorders and including them in the determination of whole person impairment for the purposes of applying subsection f). Arbitrator Wilson found that he was bound to follow the Superior Court decision in Desbiens and later cases which applied and approved Justice Speigel's approach, notwithstanding the opposition of a number of medical experts to that approach, including the insurer's assessors in the Augello case.

More importantly, Arbitrator Wilson went on to extend the interpretive principles of Desbiens. He found that the AMA Guides are incorporated by reference in the Standard Ontario Auto Policy and as a result, where competing interpretations of provisions of the Guides exist, they should be interpreted in a manner that favours the insured.

He summarized his approach in the following words:

> "As noted earlier, a determination of catastrophic impairment is the key to unlocking further, enhanced benefits under the contract of insurance. Taking such an approach, where there are two or more possible interpretations of contractual wording, relevant to coverage, the interpretation which favours the insured should prevail."

This approach of providing 'the benefit of the doubt' to the insured should inform any analysis relating to the determination of catastrophic impairment.

3. ***H.*** ***v.*** ***Lombard*** **(2007)**

The insured, represented by David Payne of Thomson, Rogers, applied for Catastrophic Designation on the basis of 55% Whole Person Impairment.

A DAC Assessment found that her impairment was 1%. After an Arbitration, in which the approach to Catastrophic Impairment Assessment was the main issue, the Arbitrator found a 79% Whole Person Impairment.

The decision stands for a number of important principles (in addition to affirming the fallibility of DACs):

1. It is proper to assign a percentage impairment to a medical impairment which has not yet occurred (in this case future arthritis);

2. Significant pre-existing injuries and impairments are not a bar to a finding of Catastrophic Impairment when those injuries are significantly exacerbated by the MVA;

3. Every impairment, no matter how small, and whether referenced in the Guides or not, is to be rated;

4. A finding of a marked impairment due to a mental or behavioral disorder in **one** of the four domains set out in the Guides satisfies the criteria for Catastrophic Impairment;

5. If there is an impairment due to a mental or behavioral disorder that is not automatically deemed catastrophic due to it not being a "marked impairment", the impairment is still to be assigned a Whole Person Impairment percentage and incorporated into the 55% calculation;

6. Notwithstanding the individual suffered from the same impairment before the accident from other causes it is only necessary to show that the MVA made a significant contribution to the impairment in order to include the impairment in the 55% calculation; and

7. Evidence from lay witnesses (friends, family, co-workers and employers) on the effect of injuries on the individual is significant and persuasive.

4. ***Pastore*** ***v.*** ***Aviva*** **(2009)**

In this case, the dispute was again over whether the insured person had suffered a Catastrophic Impairment under subsections f) or g) as the result of a 2002 MVA.

The CAT DAC found that she had a Class 4 marked impairment in the sphere of activities of daily living but that she did not meet the 55% Whole Person Impairment under section f). Arbitrator Nastasi followed Desbiens and Arts in finding that it was proper to combine psychological and physical impairments to determine a Whole Person Impairment percentage but after an exhaustive re-examination of the medical evidence concluded that the DAC assessors were correct in their determination that Pastore had not met the 55% threshold. The most significant issue relating to the subsection g) test was whether Pastore's pain disorder should be considered as a factor in assessing the impact of her injuries on her activities of daily living, since the focus of subsection g) is on mental or behavioral disorders.

The Arbitrator concluded:

> "a complete assessment must consider the effect of pain and Ms. Pastore's Pain Disorder on her activities of daily living. The pain not only limits her physical abilities to do the activity but it plays a role in the feeling of loss of meaningful activities or social relationships. This loss is noted as resulting in frustration, resentment or anger, which further increases pain."

On the issue of whether there must be a marked impairment in more than one sphere in order to meet the subsection g) test, the Arbitrator applied the principle of liberal interpretation to the legislation and, rejecting the 'Superintendents Guidelines' to the contrary, found that a marked impairment in one sphere was adequate to meet the test:

> "If an individual has reached a marked level of impairment in any one area, then they are being deprived of a level of function in a basic and core area of life.
>
> This amounts to a serious loss. It is highly unlikely that in such a case the other areas of function would not also be negatively affected in some way. Given the importance of each area of function the loss of any one alone is significant and adequate to meet the definition of Catastrophic Impairment. To accept that one marked impairment is adequate is in line with the remedial approach to the Schedule."

5. ***Liu* v. *1226071 Ontario Inc.*** **(2009)**

Mr. Liu suffered a serious head injury in a motor vehicle accident in 1999. After a trial in 2007 the judge heard a motion to determine whether the plaintiff was catastrophically impaired and thus whether, in that case, he was entitled to recover future health care expenses.

Justice Wright ruled that he was not and the plaintiff appealed to the Ontario Court of Appeal. Ambulance attendants recorded Mr. Liu's GCS at 3 approximately 15 minutes after the accident. He regained consciousness while on route to the hospital (GCS 12 and then 14) but his consciousness level remained impaired for many days following the accident.

Justice MacFarland wrote the following for the Court:

> "The respondents' objection is solely based on the fact that there were GCS's following the accident, which they submit were also "administered within a reasonable period of time after the accident". which were greater than 9."
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> "In my view the answer to the respondents' objection is the plain language of the legislation. Provided there is a brain impairment, all that is required is one GCS score of 9 or less within a reasonable time following the accident. It is a legal definition to be met by a claimant and not a medical test."
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> "I agree with the appellant's submission that the fact that there may have been other higher scores also within a reasonable time after the accident is irrelevant."

Entitlement to Med Rehab Benefits

6. ***G.B.*** v. ***Pilot Insurance Company*** (2008)

In 1998, Ms. G was seriously injured in a car accident. At the time she was 22 years old, single and childless. In 2004 she had a daughter but because of her injuries she was unable to carry out many of the activities necessary for the day to day care of her daughter. She applied to Pilot for payment of nanny expenses under the 'other goods and services' sub-section of the med/rehab section of the policy. Pilot declined payment and the matter went to Arbitration. Arbitrator Blackman allowed the claim.

Pilot appealed to the Director's Delegate who overturned the Arbitrator's decision saying that to allow nanny expenses to be claimed under the med/rehab section (S.15) would make the caregiver benefit section (S.13) meaningless.

Ms. G appealed to the Divisional Court which overturned the decision of the Director's Delegate and restored Arbitrator Blackman's decision to allow the claim under Section 15. Justice Lane for the Court concluded that S. 15 of the SABS is a broadly worded section which, in the case of a dispute, must be given an interpretation most favourable to the insured. He pointed out that nothing in S. 15 expressly excluded nanny services from the scope of med/rehab benefits.

Justice Lane went on to say:

> “Section 15 deals with the rehabilitation of the injured person herself; Section 13 deals with an allowance to replace the caregiving services which the injured person provided to others at the time of the accident.
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> The circumstances giving rise to the need are utterly different, as are the terms on which payment can be made under the two sections.
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> There is no necessary or logical inference that because such expenses can be obtained pursuant to one section of the Regulations in one set of circumstances, they could not be obtained in a different set of circumstances under a different section of the regulations ...".

In Ms. G's case the evidence called before Arbitrator Blackman made it clear that the nanny services were an integral part of a rehabilitation plan designed to 'reduce or eliminate the effects of the accident related disability and to facilitate her reintegration into her family'. This characterization is critical to funding under S.15. The decision is an inspiration to flexible readings of the med/rehab section of the policy and in particular the 'other goods and services' subsection as well as a credit to the persistence of the Ms. G and her counsel.

7. ***Pedisic* v. *State Farm Mutual Insurance Company* (2008)**

Mrs. Pedisic suffered from chronic pain as the result of motor vehicle accidents in 1997 and 2003. She engaged in a multi-disciplinary rehabilitation program which included yoga, exercise at her gym three times a week and, most contentiously, three massage therapy sessions per week. Her insurer was initially supportive of the massage therapy but after 2003 denied all expense claims related to the massage therapy. In her efforts to maintain her level of function at home and in her employment Mrs. Pedisic continued with her massage therapy and $57,000 between 2003 and 2009. State Farm continued to deny payment for the treatments on the grounds that they were not 'reasonable and necessary'. The insurer said she had developed an 'unhealthy dependence' on the therapy.

The main issue was whether long term passive therapies are reasonable in some circumstances and can therefore be funded from the med/rehab section of the SABS. An enormous amount of medical evidence was filed and called by both sides at the arbitration before Arbitrator Feldman. In the result, the Arbitrator preferred Mrs. Pedisic's experts. They were of the opinion that she was able to remain active and employed because of her massage therapy (among other treatments), and that medication was not a viable option for treatment for her long standing pain.

The Arbitrator concluded by saying:

> "While dependence on passive therapy can be a legitimate concern, in this case, the passive therapy in question is being used to support more active therapies and is being used appropriately, in a supportive role. Although the medical research may suggest that, in general, prolonged massage therapy is not helpful for most soft-tissue whiplash-type injuries, the evidence suggests that this is an exceptional case and that massage therapy, as part of a larger program, works for Ms. Pedisic."

The lesson from this decision is that conventional medical wisdom will not always carry the day - especially where you have a credible and sympathetic claimant who can demonstrate that unusual treatments are part of a thoughtful and comprehensive plan to maximize function.

Entitlement to Attendant Care Benefits

8. ***Haimov*** ***v.*** ***ING Insurance Company*** **(2007)**

In 2007, my partner David MacDonald arbitrated a case involving the entitlement to Attendant Care Benefits while his client was a patient in Sunnybrook Hospital, Toronto Rehabilitation Institute (TRI) and Baycrest. In 2005, Mr. Haimov suffered a severe brain injury in a pedestrian/motor vehicle accident. From the time he was first admitted to Sunnybrook his family took turns providing him with care and stimulation (in his own language - Russian) on a 24 hour basis. When visiting hours were more restrictive they were with him as much as was permitted by the rules.

In each case, the institution staff were supportive of the family efforts which augmented the care that staff could provide. Attendant Care Form 1's were prepared detailing the nature and level of the care that was being provided by the family. A report from Mr. Haimov's neurologist supported the need for 24 hour attendant care "in addition to the care provided by Baycrest". This was in part because the family could alert staff to the onset of a seizure thereby minimizing the negative effect on his long term health.

Arbitrator Murray found that there was "a substantial likelihood of danger to Mr. Haimov's life and health" if he was not provided with 24 hour attendant care. She rejected the evidence of the insurer's care expert for a long list of reasons and accepted the opinion of Mr. Haimov's treating neurologist on the key issue of the likelihood that Mr. Haimov would suffer anther seizure at some time in the future. The arbitrator went on to find that the attendant care being provided by family members was 'reasonable and necessary'. Although the family could not actually provide attendant care on a 24 hour basis in accordance with the Form 1s submitted - because they did not have the resources to hire a qualified person to supplement their own work - the Arbitrator ordered payment on a 24 hour basis.

The arbitrator went on to deny the insurer a deduction from attendant care benefits payable for the Long Term Care Co-payment of $1500 a month which it had been making. She found that the co-payment was a medical benefit pursuant to S.14(2)a) of the SABS for 'hospital services' rather than 'attendant care'. This case stands for the rather surprising proposition that full time attendant care services may be medically necessary and payable under the SABS even when a patient is being cared for in an acute care hospital, rehabilitation facility or long term care facility. Again we see that the provision of a well integrated and medically supported care plan makes success in these unusual claims more likely.

Availability of Section 42 Insurer's Examinations

9. *Tong v. Security National Insurance Company* (2009)

Ms. Tong was injured in a motor vehicle accident in 2003. She subsequently developed a major depressive disorder with psychotic features. My partner David Payne applied on her behalf for catastrophic impairment designation - largely on the basis of her psychological impairments as reported by her treating psychologist.

An insurer's examination was scheduled which identified her as "suicidally preoccupied" and ultimately supported the opinion of the treating psychologist with the expressed concern that she should have an in-patient assessment and treatment program. The insurer then scheduled a further battery of Section 42 insurer's examinations relating to the claim for catastrophic impairment designation.

Mr. Payne objected to the examinations and instructed his client not to attend. The issue was brought before arbitrator Wilson in January 2009. Arbitrator Wilson found that the insurer had a fiduciary (trust) relationship with Ms. Tong in regard to Section 42 examinations that required it to "not only consider Mr. Tong's interests, and balance them with its own, but must give preference to Ms. Tong's interests over those of its own." In considering whether the assessments met this test Arbitrator Wilson reviewed the evidence from Ms. Tong's treating psychologist that further assessments would cause her psychological harm and put her at increased risk of suicide. He accepted that evidence and required the insurer to make its determination of catastrophic designation based on the medical evidence that was already available to it.

The insurer sought leave to appeal from the Director's Delegate. In refusing leave, Mr. Blackman conducted an extensive review of the evidence heard by Arbitrator Wilson and concluded: "Section 42 does not give an insurer the sole and unqualified right to determine the assessment or the assessors." That right is qualified by the word "reasonable."

Ms. Tong's sad case illustrates the importance of considering, in regard to each request from an insurer for a S. 42 assessment, whether it is reasonable in the circumstances and, more importantly, whether any harm will come to the insured as a result of the 'process'. Arbitrator Wilson makes it clear that this is no less the duty of the insurer than of the lawyer acting for the insured.

As a post script, the insurer conducted a paper review of the medical evidence on the issue of Catastrophic Impairment which concluded that she met the test.

Special Awards

10. ***Michalski* v. *Wawanesa Mutual Insurance Company* (2004)**

This case is about the consequences of bad behaviour by an insurer. The Insured, Maria Michalski suffered soft tissue injuries, fractured ribs and a seizure-inducing head injury (GCS 3) in a motor vehicle accident on October 24, 2001. In November her Occupational Therapist found her to be unresponsive to greetings, disoriented on awakening and capable of answering questions only in monosyllables.

When she was discharged from hospital, her the family paid a caregiver to supervise Mrs. Michalski while her husband was at work but her 10 and 13 year old children would supervise her when they got home from school. Her husband would take over when he got home from work. Although Wawanesa appeared to know from the beginning that Mrs. Michalski was catastrophically impaired it failed to provide her with any information with regard to her entitlements and failed to pay her family for providing attendant care on an ongoing basis. They failed to advise Mrs. Michalski that she was entitled to enhanced Attendant Care Benefits ($6,000/mos) or that she was entitled to Housekeeping benefits of $100/week.

Only after the family retained counsel in 2003 did Wawanesa send a CAT application and begin to respond to claims. A CAT DAC found that Mrs. Michalski was Catastrophically Impaired in September 2004. The insurer never acknowledged that Mrs. Michalski was entitled to benefits on the Catastrophic scale. They never acknowledged or paid attendant care benefits for 24/7 care. They never paid Housekeeping benefits. After an arbitration in 2005 Arbitrator Alves found that Mrs. Michalski was catastrophically impaired and that Wawanesa owed Mrs. Michalski $100,787.65 for past Attendant Care Benefits and $7,062.18 in interest on Housekeeping Benefits (calculated to October 2004 when the insurer said it had finally paid the benefit owing). Arbitrator Alves also made a Special Award against Wawanesa saying:

> "I find Wawanesa knew the number of hours it was paying for attendant care, knew that the family members were providing the balance of Mrs. Michalski's care ... I find the blame for the unfortunate manner in which this claim unfolded rests squarely on Wawanesa's shoulders. I find Wawanesa's attempt to blame Mr. and Mrs. Michalski shows no recognition by Wawanesa of the problem which it created. In my view, that suggests that a higher special award is required."

Arbitrator Alves calculated the total amount owing to Mrs. Michalski and her family, including penalty interest at 2% per month compounded, at $237,403. This amount included $136,616 in Penalty Interest. In addition, the Arbitrator

made a Special Award of $150,000 with the following comment:

> "I believe the sanction should reflect that Wawanesa failed to meet its contractual obligations, and is entirely to blame for the manner in which this claim unfolded. I agree with the submission of counsel for the Applicant that it is difficult to find a more vulnerable Applicant than Mrs. Michalski, who, as a result of her injuries, functions like a two year old, was unrepresented by counsel and whose primary language was not English."

This Special Award was still less than the maximum that Arbitrator Alves could have awarded under the formula created by the SABS regulations. Although the Special Award was later reduced to $50,000 on appeal (with no apparent rational other than $150,000 seemed too high) Wawanesa ultimately paid $186,616 in penalties to Mrs. Michalski for its bad behavior.

This case does beg the question: 'What kind of treatment of an insured by an insurer would warrant a Special Award of the maximum permitted by the SABS?". It also makes clear the necessity of having competent counsel involved early on in any case involving Catastrophic injuries.