Accident Benefits & Spinal Cord Injuries under Bill 198

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Attendant Care Provided by Family Members in Hospital

Pay Now, Ask Questions Later

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First Step:
Determining How Much Care Required

- Complete Form 1

  How much time in rehab?
  How many nurses/floor?
  How many Nurses per patient?

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Example

- Needs 24 hour care
- 2 hours rehab per day
- 4 nurses attend 16 patients

= 1 nurse per 4 patients

= 1 nurse available approximately 6 hours per day per patient less charting time of 1 hour per day

= 5 hours OHIP funded nursing care + 2 hours rehab per day

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Does the insurer have to pay for 17 hours of care?

→ No

- Pays only for the amount of care provided
- Can wait for application for expenses

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What triggers payment?

→ Expense application by family members providing care

"Evidence that expenses have been incurred"

- McKnight and Guarantee

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What must Expense Application include?

- Names of care providers
- Dates care provided
- Approximate times of service provision

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Does the injured person have to pay family members in order to "incur" an "expense"?

→ No:

"A service needs to have been provided in order for an expense to have been incurred"

"An expense does not need to have been paid to have been incurred"

- L.F. and State Farm
- Stargratt and Zurich
- S.D. and T.T.C.

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Question:

Can the insurer object to paying attendant care while patient is in hospital "because the Hospital Act stipulates that hospitals are required to provide the level of care a patient requires while in hospital" [insurer's quote]

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Answer:

→No.

Hospital Act obliges hospitals to provide:

- accommodation
- meals
- nursing
- lab testing

BUT NOT ATTENDANT CARE

- Ministry of Health, October 2002
  Ms. Anne Utley, Senior Subrogation Officer

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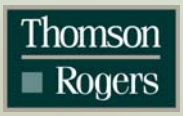
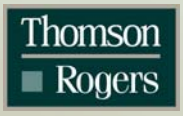
Part #2



To be or not to be?
"CATASTROPHICALLY IMPAIRED"
That is the question.

New Developments in the Law of Catastrophic Impairment



Why is being declared CATASTROPHICALLY IMPAIRED important?

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For Motor Vehicle Accidents: <u>before November 1, 2003</u>

i. You must be CATASTROPHICALLY IMPAIRED to recover, from a wrongdoer, any monies for the cost of future care.

ii. Without being declared CATASTROPHICALLY IMPAIRED, the combined attendant care and med/rehab no fault benefits care are only $170,000.00

iii. If you are CATASTROPHICALLY IMPAIRED, your combined attendant care/med/rehab no fault benefits increase to $2 million.

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On or After November 1, 2003:

i. You no longer have to be CATASTROPHICALLY IMPAIRED to claim future health care expenses from the wrongdoer who caused your injury. (You must now pass a new threshold)

ii. However, you still must be declared CATASTROPHICALLY IMPAIRED in order to have your $2 million limit in available combined attendant care/medical/rehabilitation benefits.

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On November 17, 2004, Mr. Justice Spiegel, in a detailed and thoughtful judgment in the case of *Desbiens v. Mordini*, O.J. No. 4735, provided clear guidance on how the catastrophic determination is to be made.

The decision changed many of the approaches and rules that insurers, doctors, lawyers and Designated Assessment Centres have been using when determining whether someone is, or is not, CATASTROPHICALLY IMPAIRED.

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As a result of this case, many injured victims, who never attempted to be declared CATASTROPHICALLY IMPAIRED or were determined by Catastrophic Designated Assessment Centres (CAT DACs) to not be CATASTROPHICALLY IMPAIRED, may find out that in fact they are.

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The Background:

The Law:

In order to be CATASTROPHICALLY IMPAIRED, the law states:

> "5.(1) For the purpose of subsection 267.5(4) of the Act, "CATASTROPHIC IMPAIRMENT" means…
>
> (a) Paraplegia or quadriplegia;…
>
> (f) Subject to subsections (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

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The Background:

The Law:

(g) Subject to subsections (2) and (3), any impairment that in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder…

(3) For the purposes of clause (f) and (g) of the definition of "CATASTROPHIC IMPAIRMENT" in subsection (1), an impairment that is sustained by a person but is not listed in the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993 shall be deemed to be the impairment that is listed in that document and that is more analogous to the impairment sustained by the person, 'impairment' means a loss or abnormality of a psychological, physiological or anatomical structure or function."

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The American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition:

The Guides is a book which provides a doctor with a format for analyzing, assessing and recording functional impairments to all parts of the body. After assigning a percentage value to an individual's particular impairments, a formula set out in a chart is used to combine them into a final "whole person impairment" (WPI). If this whole person impairment is 55% or above, the injured person is deemed to be CATASTROPHICALLY IMPAIRED.

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In *Desbiens*, the court made clear what it thought of using the Guides as a determining criteria for the compensation available to individuals seriously injured in a motor vehicle accident,

"While the editors acknowledge the Guides may be used in the litigation process, they caution against using the impairment percentages derived, to make direct financial awards. As Lax, J. pointed out in *Snushall v. Fulsang,* the insurance legislation in Ontario appears to require precisely what the Guides themselves discourage."

" It has also been pointed out that the Guides are not designed to assess the treatment or rehabilitation service requirements. Therefore, under Bill 59 we have the anomalous situation that the determination of entitlements to recovery of health care expenses in a tort action is governed by a set of guidelines that do not address the need for healthcare or the estimated costs thereof."

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Can an injured person's psychological impairments be given an impairment value and used towards achieving a 55% whole person impairment (CATASTROPHICALLY IMPAIRED)?

As strange as it may seem, every kind of impairment (injury) is given a percentage in the Guides, except mental or behavioural disorder injuries.

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Justice Spiegel reviewed the law, in detail, and ruled:

"I find that it is in accordance with the Guides to assign percentages to Mr. Desbiens' psychological impairments and to combine them with his physical impairments in determining whether he meets the definition of catastrophic impairment under clause (f)."

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How is the whole person impairment calculated for a person who has pre-existing impairments?

Many individuals injured in car accidents have pre-existing impairments. In Mr. Desbiens' case, they were extreme. Prior to the motor vehicle accident, he was already a paraplegic from a prior work-related accident.

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The court stated:

" A WPI of 40% when superimposed upon Mr. Desbiens' paraplegia had grave consequences for his ability to function that are not adequately reflected by a WPI of 40%. Viewed in this manner, she was of the opinion that Mr. Desbiens had sustained a catastrophic impairment in the car accident."

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As Justice Spiegel stated:

" The drafters clearly intended the definition of "CATASTROPHIC IMPAIRMENT" to be inclusive rather than restrictive."

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The Application:

Do not simply fill in a form.

In a multi-faceted injury, have a team of doctors do the completed form, preferably a team of doctors that are on CAT DACs.

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AVOID THE DELAY!

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

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.

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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.

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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.

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The Test

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.

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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.

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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.

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3. Singh v. Coseco Insurance,[2002] O.F.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.

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3. Singh v. Coseco Insurance,[2002] O.F.S.C.I.D. No. 33.

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 - 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.

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Part #3

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Rehabilitation Benefits - Housing

The rehabilitation benefit **shall** pay for reasonable and necessary measures undertaken by an insured person to:

1. Reduce or eliminate the effects of any disability resulting from the impairment, or
2. Facilitate the insured person's reintegration into his or her family, the rest of society and the labour market.

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Section 15(5)(i)

The rehabilitation benefit **shall** pay for all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident for a purpose referred to in subsection (2) for,

(i) Home modifications and home devices, including communications aids, to accommodate the needs of the insured person, or the purchase of a new home if it is more reasonable to purchase a new home to accommodate the needs of the insured person than to renovate the insured person's existing home

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Section 15(8)

The amount of the rehabilitation benefit for the purchase of a new home shall not exceed the value of the renovations to the insured person's existing home that would have been required to accommodate the needs of the insured person

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What if you didn't own a home before the accident?

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What if the home you did own cannot be modified?

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Wynn v. Belair Direct

- 2000 motor vehicle accident caused woman to be quadriplegic
- Women lived in a rented apartment

Therapist's opinion that renovations would not enable her to maximize her potential with regard to independence and life satisfaction

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Wynn v. Belair Direct

The Court's opinion

- Renovations were not reasonably possible
- Cannot do analysis under s.15(8)

Court ordered funding for a new home of $250,000 (based on houses in the area and renovation costs)

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Wynn v. Belair Direct

Insurance company appeals the decision and asks for the Order to be delayed until the appeal is heard.

The Court's decision (on the delay motion)

You must determine what it will cost to renovate the pre-accident home – even though the rented premises will not be renovated.

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Case settled before the Appeal is ever heard

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How do we use this decision?

- Still arguable that if the pre-accident home cannot be modified, the insurer may be required to fund the cost of a new home without even taking into account the cost of renovating the pre-accident home
- The cost of renovating the pre-accident home may well exceed the cost of purchasing a new renovated home
- Highlights the importance of the therapist's opinion that insured would not 'maximize her potential' without an appropriately modified home

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Drug Addiction and entitlement to No-Fault Benefits

What happens when a patient suffers post-accident drug addiction – how does that affect entitlement to benefits?

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McMichael v. Belair

- Man injured in a motor vehicle accident in 1998
- Suffered skull fracture (no LOC), fractured femur, a broken rib, fractured scapula, facial abrasions, a broken bone is his left hand, TMJ displacement, crush fracture of T9 with 25% loss of vertebral height
- Post-accident he became an abuser of cocaine after he tried to return to work 4 month post-accident and failed
- Claimed that his cocaine abuse caused him to be catastrophically impaired, unable to work and requiring care
- Long history of sporadic cocaine use – pre-accident

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McMichael v. Belair

The Arbitrator held:

- Were it not for his cocaine problems – Mr. McMichael would not be considered catastrophic and could engage in some kind of employment

The injuries are catastrophic because the cocaine abuse is a "Marked Impairment"

He is entitled to attendant care in excess of $5,000 per month

He is entitled to an ongoing income replacement benefit

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How do we use this decision?

- Drug addiction (whether a result of impaired impulse control or as a misguided attempt to self-meditate) is a direct consequence of the accident and therefore "covered" by the SABS

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Thank You!

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