Criteria for interim relief still a bit fuzzy

BY JULIUS MELNITZER
For Law Times

Designated assessment centres have been dead for over a year now. So what does a claimant do if an insurer improperly denies statutory accident benefits?

Get a lawyer, of course. But then, what does the lawyer do?

It's always handy to read the governing law. And sure enough, s. 279(1)(4.1) of the Insurance Act allows arbitrators, under the auspices of the Financial Services Commission, to "make interim orders pending the final order in any matter before the director or arbitrator."

But it's not all that clear. After all, any good governing law has some ambiguity — or perhaps any good lawyer finds an ambiguity. Finally, any good collection of arbitrators leaves some ambiguity hanging around.

But there is a common thread: lawyers write the law, lawyers deconstruct it, and lawyers interpret it. No ambiguity there.

However that may be, existing arbitral decisions are unclear on the appropriate criteria for granting interim relief under s. 279(1)(4.1).

"The majority of arbitrators have found that applicants must show urgency and a *prima facie* entitlement to the benefit claimed," says David F. MacDonald of Toronto's Thomson Rogers.

"*Prima facie* entitlement means that applicants must put forward evidence that, if uncontradicted and believed, supports a reasonable conclusion that entitlement exists."

Such evidence should include medical reports relating to the effect of the denial of benefits, affidavits of counsel delineating a relevant claims-handling chronology, and an affidavit from the claimant regarding the urgency of the matter.

The insurer has rights of cross-examination, which it can exercise either before or at the hearing. There is no appeal from an interim order and it remains binding pending settlement or an arbitration decision.

MacDonald has appeared for applicants on two recent motions for interim benefits.

In *Keyes v. Personal Insurance Co. of Canada*, Jessica Keyes had suffered catastrophic brain injuries in a 2003 car accident.

In this case, the arbitrator granted interim relief on the basis of a treating practitioner's Form 1 despite the fact that an attendant care DAC report recommended the elimination of attendant care benefits.

David MacDonald says the timeframe for completing a motion for an interim benefits order is at least two months following the denial of the benefit.

"The arbitrator found that Keyes had met her responsibility to show urgency because of the potential danger to her safety if she did not receive the appropriate attendant care," MacDonald explains.

The arbitrator also found that Keyes had demonstrated a *prima face* case of entitlement because serious questions existed on whether the DAC report had complied with the attendant care DAC assessment guidelines, the report contained significant errors or attempts to mislead regarding Keyes' pre-accident health, and the treating occupational therapist's affidavit evidence was credible and authoritative.

There was some difficulty, however, in setting the amount of the interim benefits because the attendant care needs would fluctuate depending on whether or not Keyes was in school.

"In the end, the arbitrator accepted my submission that the appropriate approach was for my client to invoice the insurer subject to a maximum set by the arbitrator," MacDonald says.

Haimov v. ING Insurance Co. of Canada was another catastrophic brain injury case. The plaintiff was an in-patient at Baycrest Hospital in Toronto, where several Form 1s were completed.

ING did not pay the attendant care benefits claimed. The insurer took the position that attendant care was OHIP's responsibility. It also maintained that it had met its obligations when it made its co-payment of approximately $1,500 monthly under the Long Term Care Act.

Haimov succeeded on an application for interim relief.

"Although the arbitrator's reasons have not been released, the fact that the arbitrator ordered additional payments of $6,000 monthly in attendant care suggests that he accepted my argument that the co-payment was for payment of accommodation and meals rather than for attendant care," MacDonald says.

It also seems clear that the arbitrator rejected the s. 42 evaluator's conclusion that Haimov required hundreds, as opposed to thousands, of dollars for attendant care.

"The s. 42 valuator had focused upon who should be meeting the need rather than identifying the need," MacDonald notes.

"The arbitrator plainly disagreed with the evaluator's conclusion that the hospital was responsible for providing attendant care."

According to MacDonald, the time frame for completing a motion for an interim order for benefits will normally be at least two months following the denial of the benefit. LT