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Attendant Care Benefits: Understanding the Basics

Interplay Between Accident Benefits and Tort

Similar to claims for housekeeping and caregiver benefits, a claim for attendant care benefits is virtually impossible to independently verify for the basic, non-catastrophic claimant. These cases often come down to whether a clamant can or cannot clip her own toe nails and put on her own shirt. Clearly there are a fair number of both legitimate cases and outright frauds. When dealing with a basic claim for attendant care benefits revolving around soft tissue pain complaints, the trick is how to decipher the good from the bad.

For a tort adjuster, claims for attendant care benefits are now compensable under Bill 198 as they are properly considered to be a health care expense. Claimants build the exposure for attendant care expenses in the accident benefits world to later be used in the tort realm. A claimant is only entitled to receive a maximum of $3,000.00 per month, for a total of two years, for non-catastrophic accident benefits claim. Afterwards, the only recourse is the tort defendant. It is therefore important for a tort adjuster to understand how an attendant care benefit is generated. It will come as no surprise that payment or non-payment of attendant care benefits often is on account of procedural irregularities as opposed to a legitimate substantial need of a claimant.

The WAD I and WAD II Claimant

Section 16 (1.1) of the *Schedule* states that if the accident occurred after April 14, 2004 that no attendant care benefit is payable to an insured person whose impairment is a Grade I or Grade II whiplash-associated disorder that comes within a Pre-approved Framework Guideline. At first blush, this would appear to nullify the vast majority of claims for attendant care benefits for claimants alleging to have suffered soft tissue injuries. The language appears straight forward and simple. However, to deny payment of attendant care benefits on the basis of this statutory language without conducting the appropriate insurer examinations is a risky proposition.

It is not difficult for a claimant to prove that the injuries sustained fall outside of the pre-approved framework. In *Mernai v. Wawanesa* (2008), the claimant's injuries included soft tissue pain complaints to her neck, back, swelling to left knee, wrist, and thumb. Wawanesa denied the claim for attendant care benefits solely on the basis that the whiplash-associated disorder came within the PAF and did not conduct any insurer examinations. The Arbitrator found that the injuries to her wrist, thumb, and left knee set her impairments outside of the PAF and ordered attendant care benefits to be paid. This is despite the fact that these injuries were not much more then a strain. There are a multitude of examples of health issues that can easily be interpreted by an Arbitrator to take the claimant out of the PAF such as: psychological problems, radiculopathy, migraines,

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and a pre-accident medical history that has been aggravated by the accident. It is not advisable to simply deny entitlement to attendant care benefits on the basis of an alleged WAD I or II disorder without performing an insurer examination as a back-up.

The Claimant Who Never Provides a Form 1

Section 16(4) of the *Schedule* specifies that the monthly amount payable by the attendant care benefit shall be determined in accordance with a Form 1. Since the *Schedule* makes it clear that the entitlement to attendant care benefits "shall" be determined in accordance with a Form 1 – it seems logical to assume that a claimant needs a Form 1 in order to prove entitlement to such a benefit.

The law, however, is not so clear. In *Valle v. Aviva Canada Inc*. (2005), *A.K.P. v. ING Insurance Company of Canada* (2006) and *Buccellanto Estate v. Allstate* (2004) a Form 1 was not prepared by the claimant in any of these cases to support a claim for attendant care benefits. Rather than rejecting these claims outright due to the failure to comply with this procedural requirement, the Arbitrators continued to hear the Applicants evidence. The Arbitrators denied entitlement to attendant care benefits in each of these cases based on the finding that the applicants' evidence was unreliable. However, it appears that the Arbitrators may have considered the oral and other documentary evidence of the applicants to establish a viable claim for attendant care benefits despite the fact that a Form 1 was not provided. So, the absence of the production of a Form 1 itself may not be fatal to an Applicant's claim for attendant care benefits.

Credibility Challenges Are the Best Defence

Since the need for attendant care is highly subjective in nature, credibility is key. Successful challenges to the need for attendant care have revolved around inconsistencies in the oral evidence given by a claimant, (or witnesses), and the written documentation. It is therefore very important to require the claimant to provide invoices of attendant care he received, carefully review the assessments, and consider what the claimant does on a daily basis. In *McKnight v. Guarantee Co. Of North America* (2003), the Arbitrator held that an insurer is entitled to request information identifying the service provider and the dates and approximate times of service provision in addition to the Form 1 before paying an attendant care benefit. The following two cases are illustrative of how an insurer has successfully defended claims for attendant care.

In *Piche v. Allstate* (2008), the claimant alleged that her mother helped her with "everything", including: getting in and out of bed, toileting, showering, washing, getting dressed and other personal care activities. Yet the oral evidence of the claimant and her mother at the Arbitration, as well as a careful review of the invoices, suggested that that the claimant gradually required less assistance as time passed. The in-home assessment and DAC assessment concluded that the claimant did not require any further attendant care needs. The Arbitrator found that the assessments provided more reliable evidence than the evidence of the claimant and her mother and denied to the claimant entitlement to any further attendant care benefits.

In *Hasan v. State Farm* (2007) the claimant testified he was unable to perform his personal care activities following the accident, such as dressing himself, getting in and out of the shower, shaving, brushing his teeth, and using the washroom for two months post accident. Mr. Hasan submitted invoices for attendant care which indicated that he received two and a half hours of attendant care each day for the two months following the accident. However, he admitted at the Arbitration that no one helped him to use the washroom at work over this same period of time. The claimant told a different assessor that he only required attendant care benefits for just one month post accident. Moreover, the Arbitrator found it significant that the claimant had returned to work one week following the accident and that he performed a significant amount of overtime for at least the first month post-accident. If the claimant could not brush his own teeth, how would he be able to work overtime hours as a general labourer? Ultimately, the arbitrator concluded that the claimant's evidence on the type and extent of attendant care he received to be unreliable and no such benefits were ordered to be paid.

The Claimant Who Never Receives Any Attendant Care

One of the controversial issues is whether the expenses for attendant care have in fact been "incurred" which is apparently required as per Section 16(2) of the *Schedule*. Quite simply, if no one has in fact provided the claimant any attendant care, how can he claim entitlement to such a benefit? In *Belair v. McMichael* (2007), a drug addict claimant alleged that he required attendant care services, but could not afford to pay anyone, and therefore did not receive or incur any such assistance. He managed without the assistance. The Court found that if the benefits are deemed reasonable than an insurer is obligated to pay the cost of the attendant care benefits; even though there is no one performing the attendant care. If the benefits are reasonable and necessary, an insurer will not be able to

rely on the fact that the no one in fact provided the services.

Payment To A Family Member And To A Long Term Care Facility

There are a number of cases that address whether a claimant is entitled to receive attendant care benefits both for care provided at a long-term care facility, and for family members who visit/care for him at this facility. The cases suggest that only when the claimant is suffering from very significant injuries, and there is concern for the claimant's welfare, that an insurer may be found obligated to pay for both the cost of the facility and for family members, (or other caregivers), at the same time.

In *Haimov v. ING Insurance Co. of Canada* (2007), a claimant was admitted to long-term care facility for 24 hour treatment on account of the injuries he sustained in the accident which was paid for by the insurer. However, he did not have individual care at night and the claimant's family sought further attendant care benefits with regards to same. The Arbitrator found that there was a substantial likelihood of danger to the claimant's life if someone was not with him 24 hours a day and ordered compensation for this level of attendant care.

On the other hand, in *Fernendes v. Certas* (2006), the claimants request for additional attendant care was denied. In that case, the claimant was sent to a long-term care facility following an accident in which he was catastrophically injured. His family argued that the long-term care facility was inadequate as they pointed to a number of slip and falls, incidents, and frequent occasions in which the claimant was being left alone. The Arbitrator concluded that there were isolated incidents and that long-term care facilities cannot be forced to a standard of perfection. The Arbitrator found that the facility had met the requisite standard of care and that additional attendant care was not reasonable or necessary.

Conclusion

In conclusion, procedural defences to claims for attendant care are challenging to uphold. As with most things, a trier of fact is more inclined to decide an issue based on the merits of the claim as opposed to procedural niceties. If a claimant is credible, then he will likely be found to be entitled to some attendant care benefits. This is despite the fact that he may only suffer from a WAD II injury, may not have provided a Form 1 on time, and may not have even had anyone provide him with the required attendant care. Although this is in complete defiance to the wording of the *Schedule*, it is the law as we know it. It is imperative that an insurer gather as much information as possible on the claimant, and attendant care providers, in an attempt to weed-out the good from the bad. By carefully attending to claims for attendant care, an astute adjuster may be able to limit the exposure for such benefits.

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