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The Major Impact of the New "Minor Injuries" Category

The new changes that have come into affect September, 2010 to the accident benefits regime will have a significant impact on insurance litigation. Whereas the goal may have been in part to, "simplify the system", the affect of same will undoubtedly create more confusion and litigation. This no more evident then in the changes creating a new classification of "Minor Injuries" as set out in Section 18 of the *Schedule*. Not only will this have a significant impact on the adjusting of accident benefits claims, but it will create new issues and increased exposure on the tort side as well.

Section 18(1) states as follows:

> "The sum of the medical and rehabilitation benefits payable in respect of an insured person who sustains an impairment that is predominantly a minor injury shall not exceed $3,500.00 for any one accident, less the sum of all amounts paid in respect of the insured person in accordance with the Minor Injury Guideline."

Section 3 of the Regulation defines minor injuries as follows:

> "Minor injury" means a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and any clinically associated sequelae
>
> "Sprain" means an injury to one or more tendons or ligaments or to one of more of each, including a partial but not a complete tear;
>
> "Strain" means an injury to one or more muscles, including a partial but not a complete tear;
>
> "Subluxation" means a partial but not a complete dislocation of a joint;
>
> "Whiplash associated disorder" means a whiplash injury that,
>
> (a) does not exhibit objective, demonstrable, definable and clinically relevant neurological signs and;
>
> (b) does not exhibit a fracture in or dislocation of the spine"

Entitlement to Treatment for a "Minor Injury" is $3,500.00

Accordingly, if an injury is ultimately classified as a "Minor Injury" this restricts the claimant's entitlement to medical benefits to a maximum of $3,500.00. Whereas the prior entitlement to medical benefits was $100,000.00, this has now been reduced to 3.5% of that sum. Although it was very rare that a typical soft tissue pain case would come close to reaching the prior $100,000.00 cap, it was very common that these cases would far exceed $3,500.00.

In addition, the $3,500.00 maximum entitlement to medical treatment also includes the cost of any medical assessments. So, if the claimant obtains an assessment by a physiatrist at a cost of $2,000.00, then the claimant is only entitled to $1,500.00 for treatment.

This undoubtedly reduces the exposure to accident benefits insurers.

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However, the corollary of the benefit to accident benefits insurers is the negative impact on tort defendants. After a claimant reaches the $3,500.00 cap for benefits on the accident benefits side, the last pocket left to pick is that of the tort defendant. A claimant may attend treatment and eventually submit a bill to the tort defendant months or years after the fact. At that point it will be very difficult for a tort defendant to go back in time and say that the treatment was not needed. In the old regime, an accident benefits carrier had the opportunity to conduct an insurer examination to determine entitlement to the treatment before it was incurred. The tort defendant will not have this luxury. Exposure to the tort insurer for past medical expenses has thus been increased. And, it will be very difficult to defend against such claims.

Definition of a "Minor Injury" Is Broad

As set-out in Section 3, the definition of a "minor injury" is quite broad; much more so then the prior PAF definitions. Indeed, it not only includes WAD II injuries, but also partial tears, and partial dislocations. This means that a claimant who has suffered from a partial rotator cuff tear would be considered to have suffered a "minor injury".

In the prior legislation, claimants were able to successfully argue that their injuries fell outside of the PAF guidelines by arguing that they suffered from psychological problems or other injuries such as a strained thumb. Section 18 (1) of the present limitation attempts to curtail such arguments by stating that if the impairment is "predominantly a minor injury" that the entitlement shall not exceed $3,500.00. As such, if a claimant suffers from depression on account of the fact that his WAD II injury prevents him from doing the things he did beforehand, presumably the injury is still a "minor injury". If the root of the injury falls within the scope of a "minor injury" then any side effects does not change the entitlement.

Chronic Pain and a "Minor Injury"

Unlike the prior PAF system, there does not appear to be any statutory language that allows a claimant to get out of the "Minor Injury Guidelines". As such, if a claimant is determined to have suffered a "Minor Injury" then there does not appear to be a mechanism to change this classification. This is particularly important when it comes to the definition and diagnosis of chronic pain.

The established medical convention is that chronic pain is an ongoing pain complaint that has persisted for greater then six months. Many claimants alleged that their WAD II complaints have gone on to develop into chronic pain and they require various forms of physical therapy, psychological treatment, injections, chronic pain programs, and the like. According to the new changes, by the time that six months has passed since the day of the accident, the claimant will have by far exceeded the $3,500.00 to which he is entitled. If he cannot change his categorization of suffering from a "Minor Injury", he will certainly not obtain the desired treatment.

There is a live question as to whether chronic pain is a "minor injury". Chronic pain is often composed of a WAD II injury, partial tears, and strains/sprain. Chronic pain also includes a psychological element that is often secondary to the musculoskeletal complaints. This appears to meet the definition of a "minor injury". Yet, chronic pain is also more then the sum of its parts. It has been recognized both in the medical field and in the case law as a distinct medical condition. Most claimants who sufferers from soft tissue injuries allege that they are suffering from "chronic pain" whether they do or they don't. Now there may become a distinct difference as to true chronic pain sufferers who fall outside the "minor injury" guidelines and those who still fall within. Litigation will certainly arise to sort this all out.

Consequences of the Minor Injury Guidelines

The ultimate affect of this is that claimants may incur out-of-pocket expenses to pay for this treatment, may enter agreements with facilities to pay for the treatment later, enter into agreements with litigation loan companies that will charge high interest rates, or not go for the treatment at all. With respect to the high interest litigation loan companies, this will be an incurred expense that will be claimable on the tort side thereby increasing exposure. This is a growing trend in the East Coast of Canada.

In terms of the claimants not going for treatment, this may result in claimants suffering significant deteriorations in their conditions resulting in larger claims. If a claimant cannot get back to the workforce because he could not afford to pay for treatment, then this will result in much more significant income loss claims then we have dealt with in the past. This may increase the claims being made for income replacement benefits and attendant care benefits on the accident benefits side. Similarly, claims for income loss, general damages, housekeeping, and health care expenses will increase on the tort side.

On the tort side, insurers will likely see an increase in claims for advance payments in order that claimants may access treatment once their $3,500.00 entitlement runs dry. If a defendant insurer refuses to pay for the treatment, then it will have a difficult time

arguing that the claimant failed to take action to mitigate his injuries later on in the litigation. This will also increase the work required to be performed by the tort adjuster at an earlier stage as she will be left to decide whether the claimant needs further treatment. A tort adjuster will also be left on her own to make this decision without the benefit of an insurer assessment which would normally be available to an accident benefits adjuster.

There is also a distinct possibility that claimant's counsel will attempt to build-up a cost award/punitive damages claim against the tort defendant. This is not something that we see frequently, if at all, in the past. Plaintiff counsel may write letters to the tort insurer and/or directly to the tort defendant's insured requesting advance payment for treatment. Whereas letters written to a tort defendant's insurer may not be admissible at Trial, (Juries are not supposed to be aware that there is an insurer defending the case), there is nothing to say that letters written to an insured are inadmissible. If it is determined at trial that the failure to provide an advance payment to the claimant for treatment was inexcusable, this may result in a high cost award or punitive damages award against the Defendant. In these cases further questions become pertinent such as: (1) If there is a punitive damages award, does the policy of insurance provided to the tort insured cover this? and (2) Does this create a conflict of interest between the tort defendant insurer and the insured?

On the tort side, smart insurers may use the designation of a "Minor Injury" on the accident benefits side to assist their case. It is likely that the designation of a "Minor Injury" will have little impact on a Judge when deciding whether the claimant has passed the threshold as these are two distinct legal tests. One is a claim for medical benefits on a first party basis and the other a test of disability. A Judge can distinguish this in his mind. However, a Jury is given the responsibility of making a determination as to the value of the claim. And Juries are not as caught-up in legal hair-splitting as Judges, lawyers, and insurance adjusters are. If a Jury hears that the claimant was found to suffer a "Minor Injury", then they may also conclude that this should entail a minor pay-out.

On the accident benefits side, I believe that we will see an increase in motions/preliminary issue hearings as to whether the claimant has suffered a "minor injury" or not. These motions will likely take place right near the onset of the claim and require accident benefits carriers to retain counsel sooner then anticipated thereby increasing costs.

Pre-Existing Medical Conditions and a "Minor Injury"

Section 18(2) of the *Schedule* has carved-out a way for a claimant to establish that his injuries fall outside of the "Minor Injury Guidelines":

"Despite subsection (1) the $3,500.00 limit in that subsection does not apply to an insured person if his or her health practitioner determines and provides compelling evidence that the insured person has a pre-existing medical condition that will prevent the insured person from achieving maximal recovery from the minor injury if the insured person is subject to the $3,500.00 limit or is limited to the goods and services authorized under the Minor Injury Guideline."

According to this section, if a claimant suffers from a pre-existing medical condition that will impact his ability to reach maximal recovery, as supported by a health practitioner, then he may fall out of the Minor Injury Guidelines. The *Schedule* states that a health practitioner includes physicians, occupational therapists, physiotherapists, registered nurses, and chiropractors.

I note that the words "compelling evidence" was included in the language of this section as opposed to simply the word "evidence". Presumably this means that the burden of proof for the claimant is higher then simply to provide "evidence" alone. No guideline has been provided as to what this actually means. Indeed, does a physiotherapist have the medical expertise to provide "compelling evidence"? Unquestionably this word will become a source of litigation.

Conclusion

The consequences of the creation of the "Minor Injuries" class of claimants will have a substantive impact on the adjusting of accident benefits and tort claims. If a claimant falls under this definition then he is limited to an entitlement of $3,500.00 in treatment and assessments. Plaintiff counsel will undoubtedly commence motions/preliminary issue hearings to challenge this classification. They will also drive-up the exposure on the tort side for past medical expenses and seek advance payments to provide treatment to their clients.

Legitimate claimants who do not receive the treatment they need may ultimately see a deterioration in their condition resulting in larger tort and accident benefits claims (for instance if they cannot return to work). Indeed, there is even the possibility of punitive damages/high costs awards against tort insured's/insurers if they

unreasonably withhold advance payment for treatment.

The definition of a "Minor Injury" is ripe for dispute. Is chronic pain a "minor injury"? What constitutes a "predominantly a minor injury", and what does "compelling evidence" mean? How is an insurance adjuster supposed to make these determinations where I suspect doctors will be equally baffled by this language.

At this juncture, it appears that accident benefits adjusters are being left to their own devices to make the difficult decision as to who falls under the category of a "Minor Injury". The Courts will then assess these decisions through the litigation process and perhaps provide some guidelines as to what the legislators meant by these changes. The Court of Appeal will ultimately get a chance to weigh-in on this as well. Undoubtedly the way we interpret the section today will not be the same as we do in the future. I believe that the hallmark of the "Minor Injury" classification will be upheaval in the insurance regime and costly litigation.

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