BEARDWINTER LLP

Defender

Vol.7 | Issue 3
August, 2013

Need to Know: Four Recent and Key Accident Benefits Decisions

The *Statutory Accident Benefits Schedule* does not make for easy reading. The language is not always clear and the judicial interpretation often seems to befuddle someone's view of common sense. Every few years the legislature, with good intention, tries to rework the *Schedule* to address stakeholders concerns which invariably results in more legal disputes. While as the changes to the *Schedule* has given rise to new debates, there continues to be disputes as to what the existing language means.

Below I have identified four of the most recent and important decisions which address everyday handling issues such as: (1) What is an "Economic Loss"? (2) When does an injury fall within the "Minor Injury Guideline"? and (3) Is an insurer required to pay for a private MRI expense?

Henry v. Gore Mutual Insurance Company (2012) Incurred Expense and Economic Loss

The determination of what constitutes an "incurred" expense and an "economic loss" was front and centre in the decision of *Henry v. Gore Mutual Insurance Company* (2012). That case dealt with an 18 year old claimant who suffered from a catastrophic injury and was being provided attendant care benefits from his mother. His mother had quit her job in order to provide for the care for her son and there was no issue that she had suffered an economic loss; just the issue as to how to quantify same. The claimant submitted a Form 1 which totalled $9,500 and accordingly the maximum payable was $6,000 monthly. Rather then paying $6,000, the insurer calculated the amount of time that the mother spent providing the attendant care and multiplied this by the hourly rates set-out in the Form 1. This straight-line mathematical formula equalled a monthly rate of $2,117.40; which is a far cry from $9,500. It was left to the Court to decide if the monthly rate should be $6,000 or $2,117.40.

By way of a succinct ruling, the Court found that "economic loss" is not defined in the regulations. The Court found that there is nothing in the legislation that sets out a calculation of the amount of an economic loss, but rather simply if an economic loss exists. Once the claimant passes a "threshold" finding for an "incurred expense" then all reasonable and necessary attendant care expenses must then be paid as per the Form 1. The insurer was found to owe the claimant the $6,000 maximum monthly amount.

Based on this decision, if a claimant can prove that he has suffered an "economic loss" for a claim for attendant care benefits, then he is entitled to reasonable expenses as per his Form 1. Presumably, this means that if a claimant can establish that he has suffered one dollar worth of an "incurred expense" for monthly attendant care benefits then the claimant is not owed just one dollar, but rather what is reasonably contained in the Form 1.

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With that being said, the decision by the Arbitrator in *Simser v. Aviva Canada* (2012), rejected this "threshold" finding for an incurred expense.

Simser v. Aviva Canada (2012) Incurred Expense and Economic Loss

In *Simser v. Aviva Canada* (2012) the issue of how one defines an "economic loss" was again put to the test. In that case, evidence was introduced by a claimant economist that defined "economic loss" in broad terms to include: loss of income, loss to time devoted to labour, and loss of time devoted to leisure to name just a few. In short, the more time spent providing for attendant care/ housekeeping to a claimant means a loss of opportunity to use that time to do other things; an "alternative opportunity cost".

The Arbitrator rejected this expansive definition of "economic loss" and preferred a more "everyday meaning of those words" such as a true financial or monetary loss. The Arbitrator found that the service providers failed to prove a quantifiable economic loss and the claim for attendant care/housekeeping benefits was dismissed.

In addition, the Arbitrator also seems to have rejected the "threshold" rationale advanced by the Court in *Henry v. Gore*. In this case, Aviva wrote to the claimant and accepted that about $50.00 was payable to the claimant for fuel, parking, and meals as a "documented incurred expense". The claimant argued that since the "threshold" provisions had been met, that now the insurer is obligated to pay to the claimant the full attendant care rate as set-out in the Form 1 (citing *Henry v. Gore*).

The Arbitrator rejected the claimant's arguments. Firstly, he found that the two cases are dissimilar as it was clear that the service provider in *Henry v. Gore* has sustained a concrete loss of income based on the service provider remaining at home from her full time employment. Secondly, the Arbitrator found that the claimant's "threshold" interpretation would mean that every service provider "would be able to circumvent the amended regulations by purchasing a single meal in a restaurant, a tank of gas or a bus ticket. This interpretation would again render the amendment meaningless and superfluous".

As such, the Arbitrator restricted the definition of an "economic loss" to a concrete financial loss, and found that it must also constitute something more then a trivial out of pocket expense.

Scarlett v. Belair Insurance Company Inc. (2013) Minor Injury Guideline

This decision is presently under appeal.

At issue in this case was whether the claimant has suffered an injury that falls within the Minor Injury Guideline ("MIG)"). On the basis of statutory interpretation and substantive reasons, the Arbitrator found that the claimant has not suffered an injury that falls within the MIG. Indeed, the Arbitrator seemed to call into question the significance and impact of the new guideline altogether.

Firstly, the Arbitrator found that the "guidelines (MIG) are informational and non-binding, providing only that they be considered". This is different then the provisions of the *Schedule* which are created by the legislature and are binding. He was prepared to consider the language of the MIG, but did not feel obligated to be bound by it. This reduced the impact of the MIG on the Arbitrator's decision making.

Secondly, from a statutory interpretation standpoint, the Arbitrator decided that the phrase "compelling evidence" that is set out in the MIG does not necessarily create a more difficult burden on the claimant then simply regular evidence. The MIG provides that if a claimant provides "compelling evidence" that he has suffered a pre-existing health condition that has impacted his ability to recover from injuries sustained in a motor vehicle accident, that he will be taken out of the MIG. The issue is what is the difference between "compelling evidence" and regular evidence? In a nutshell, if the claimant was obligated to prove "compelling evidence" then it is more difficult for him to establish that he has suffered a non-MIG injury.

The Arbitrator found that the claimant does not necessarily have to meet the more difficult burden of proof. In part, he relied on the subtle differences between the English and French versions of the MIG where the definition of "compelling" evidence in the French version would be better interpreted as "convincing" evidence. The Arbitrator found that "convincing" is less difficult to prove then "compelling" and therefore there is a conflict between the French and English versions. Since both versions are official, both should be given equal weight.

From a substantive basis, the Arbitrator accepted the evidence of the reports of the claimant's orthopaedic surgeon, psychologist, and TMJ specialist who found that the claimant has suffered an injury that falls out of the MIG on account of his diagnosed chronic pain, emotional problems, and TMJ complaints. This was in

contrast to the conclusions reached by the insurer assessments by a chiropractor, psychologist, and a paper-review by a dentist that found the claimant suffered uncomplicated soft tissue injuries and did not want to go for psychological treatment. The Arbitrator found that while as the insurer examinations may disagree as to the conclusions reached by the claimant assessors "that is the very sort of conflict that is meant to be resolved in court or by arbitration, on the issue of reasonableness of the particular treatment proposed, not by a unilateral veto of benefits by the Insurer".

Ultimately, the Arbitrator considered the minor injury guideline, but did not find it to be binding. In terms of the guidelines themselves, he did not accept that the phrase "compelling evidence" necessarily resulted in the claimant having to prove a more onerous burden then regular evidence. On the basis of this background, he analysed the medical reports put in front of him, (there was no oral witnesses called), and found that the claimant has not suffered an injury to which the MIG applies

Federico v. State Farm (2012): Obligation To Pay For An MRI Expense

In *Federico v. State Farm* (2012), the Arbitrator found that the insurer is obligated to pay for the cost of an MRI despite the fact that this had been funded already by OHIP. The Director's Delegate overturned this decision on appeal. The Director's Delegate found that the MRI Section 24 expense was reasonably available under OHIP and accordingly the insurer is relieved of the obligation to pay for this expense. Once it is determined that this is an expense that would be covered by OHIP the insured bears the burden of proving how much is available under the collateral benefits plan (in this case OHIP) before submitting it to the accident benefits insurer for payment.

In this case, the MRI was conducted 5 weeks after the treating doctor recommended it be performed and it was covered by OHIP. It was found that 5 weeks was a reasonable period of time for a claimant to wait for an MRI and that "payment from another plan or law was reasonably available".

While as this decision was argued based Section 60(2) of the Old Regulation, the language of that section is exactly the same as Section 47(2) of the present legislation. Accordingly, the law with respect to claims for MRIs in a post- September 2010 world should be the same as pre-September, 2010.

This is a very important decision as claimants have routinely sought payment of private MRIs where the complaints are uncomplicated soft tissue injuries. These private MRIs are being conducted with limited wait times and at significantly higher cost then that which is charged to OHIP. If a claimant's treating doctor determines that an MRI needs to be conducted then he will requisition one to be performed via OHIP in the ordinary course of treatment. Indeed, if the treating doctor believes that an MRI needs to be performed on an emergency basis then this too can be arranged. Claimants are seeking to bypass the pubic health realm for private MRIs often without due regard if these are necessary. In fact, it is often a chiropractor who is recommending that a privately funded MRI be performed when such a health practitioner is not even qualified to recommend that such a diagnostic test be conducted in the OHIP realm.

With that being said, one of the important aspects of the *Federico v. State Farm* decision is that the wait time for the claimant was only 5 weeks. The claimant did not incur an expense for the MRI as it was OHIP funded. The decision by an Arbitrator may be different in a case where the wait time for the MRI is significantly longer and the injuries may be more complicated.

Conclusion

Knowledge of the law is important for both adjusting claims and negotiating settlements. This is all the more pronounced in the realm of accident benefits where the new changes to the *Schedule* have resulted in a host of unanswered questions. *Henry v. Gore Mutual Insurance Company* suggests that the claimant may only need to prove some sort of undefined "Economic Loss" expense in order to get over the threshold for an entitlement to attendant care benefits. *Simser v. Aviva Canada* comes to the alternative conclusion that a substantial incurred expense must be established. In *Simser v. Aviva Canada* the definition of "Economic Loss" was restricted to concrete financial losses as opposed to a more broad loss of opportunity costs definition. Accordingly, there are two decisions released so far regarding the definition of "Economic Loss" and two different interpretations.

In *Scarlett v. Belair Insurance Company Inc.* the Minor Injury Guideline was found to be non-binding and the burden of proof on the claimant was watered down. It remains to be seen what will be the result on appeal. Probably the most important determination left unanswered is whether chronic pain falls within the definition of a Minor Injury Guideline.

Federico v. State Farm stands for the proposition that MRI expenses are non-payable under the *Schedule* if they are covered by OHIP within a reasonable period of time. What has not been decided

is what is considered to be a reasonable period of time and what happens if we are dealing with complicated injuries.

By using our insight of the ever-changing law of accident benefits we will be in a good position to understand the nuisances of the *Schedule* and adjust our strategies accordingly. Using our knowledge of the law to our advantage is one of the best ways of achieving a good resolution.

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